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No. 16-149

IN THE
Supreme Court of the United States

COVENTRY HEALTH CARE OF MISSOURI, INC.,

Petitioner,

v.

JODIE NEVILS,

Respondent.

On Petition For A Writ Of Certiorari To The Supreme Court Of Missouri

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

The Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. § 8901 *et seq.*, governs the health benefits of millions of federal workers and dependents, and authorizes the Office of Personnel Management ("OPM") to enter into contracts with private insurance carriers to administer benefit plans. FEHBA expressly "preempt[s] any State or local law" that would prevent enforcement of "the terms of any contract" between OPM and a carrier which "relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)." *Id.* § 8902(m)(1). In a 2015 regulation, OPM codified its longstanding position that FEHBA-contract provisions requiring carriers to seek subrogation or reimbursement "relate to ... benefits" and "payments with respect to benefits," and therefore FEHBA preempts state laws that purport to prevent FEHBA insurance carriers from pursuing subrogation and reimbursement recoveries. 5 C.F.R. § 890.106(h). Expressly disagreeing with multiple federal circuits and state appellate courts, the Missouri Supreme Court nevertheless construed FEHBA not to preempt such state laws—explicitly refusing to accord any deference to OPM's regulation. A majority of the court further concluded that Section 8902(m)(1) violates the Supremacy Clause of the U.S. Constitution. The questions presented are:

1. Whether FEHBA preempts state laws that prevent carriers from seeking subrogation or reimbursement pursuant to their FEHBA contracts.

2. Whether FEHBA's express-preemption provision, 5 U.S.C. § 8902(m)(1), violates the Supremacy Clause.

PARTIES TO THE PROCEEDING AND RULE 29.6 STATEMENT

All parties to the proceeding are named in the caption.

Xerox Recovery Services, Inc. (formerly known as ACS Recovery Services, Inc.) intervened as an additional defendant in the case, but Xerox and Nevils subsequently settled the claims as between themselves. Xerox is no longer a party to this litigation and did not participate in the case in the Missouri Supreme Court on remand from this Court.

Pursuant to this Court's Rule 29.6, petitioner Coventry Health Care of Missouri, Inc. (formerly known as Group Health Plan, Inc.) is a wholly owned subsidiary of Aetna Health Holdings, LLC (successor by merger to Coventry Health Care, Inc.). Aetna Health Holdings, LLC, in turn, is a wholly owned subsidiary of Aetna Inc. Aetna Inc. is a publicly traded corporation that has no parent corporation, and no publicly held corporation owns 10 percent or more of its stock.

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PETITION FOR A WRIT OF CERTIORARI

Petitioner Coventry Health Care of Missouri, Inc. (formerly Group Health Plan, Inc.) respectfully petitions for a writ of certiorari to review the judgment of the Supreme Court of Missouri.

OPINIONS BELOW

The Missouri Supreme Court's opinion under review (Pet. App. 1a-14a) is not yet reported but is available at 2016 WL 3919334. That court's prior opinion (Pet. App. 44a-72a) is reported at 418 S.W.3d 451. The Missouri Court of Appeals' opinion (Pet. App. 33a-43a) is not reported but is available at 2012 WL 6689542. The Missouri Circuit Court's decision (Pet. App. 28a-32a) is not reported. The U.S. District Court for the Eastern District of Missouri's ruling remanding the case to state court (*id.* at 15a-27a) is not reported but is available at 2011 WL 8144366.

JURISDICTION

The Supreme Court of Missouri entered judgment on May 3, 2016, accompanied by an opinion adjudicating the federal questions presented here. This Court has jurisdiction under 28 U.S.C. § 1257(a). *See Cox Broad. Corp.* v. *Cohn*, 420 U.S. 469, 476-87 (1975); *infra* pp. 36-37.

RULE 29.4(b) STATEMENT

The decision below calls into question the validity of 5 U.S.C. § 8902(m)(1). The United States was not a party in the state-court proceedings (but participated as *amicus* below and previously in this Court). Section 2403(a) of Title 28, United States Code, thus may now apply.

CONSTITUTIONAL, STATUTORY, AND REGULATORY PROVISIONS INVOLVED

Section 8902(m)(1) of Title 5, United States Code, provides:

> **§ 8902. Contracting authority**
>
> * * *
>
> (m)(1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.
>
> * * *

Section 8913(a) of Title 5, United States Code, provides:

> **§ 8913. Regulations**
>
> (a) The Office of Personnel Management may prescribe regulations necessary to carry out this chapter.
>
> * * *

Other pertinent constitutional, statutory, and regulatory provisions are reproduced in the Appendix at 75a-115a.

STATEMENT

For the second time in three years, the Missouri Supreme Court has held that States may nullify key terms of *federal* contracts—governed by a *federal* statute with a sweeping express-preemption provision, 5 U.S.C. § 8902(m)(1)—entered into by a *federal* agency to provide employee benefits for the *federal* workforce. The decision below solidifies two lower-court conflicts, holds a federal statute unconstitutional, and jeopardizes a massive, multibillion-dollar program that serves 8 million federal workers and dependents.

In 2014, the Missouri Supreme Court—directly contrary to decisions of the Eighth Circuit and Georgia Supreme Court, among others—held that the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. § 8901 *et seq.*, does not preempt state laws barring FEHBA carriers from seeking subrogation or reimbursement, even when required to do so by their FEHBA contracts with the Office of Personnel Management ("OPM"). Pet. App. 46a-54a. Coventry sought certiorari, and the United States (whose views this Court invited) agreed that the Missouri court's decision addressed an important federal question, split with other courts, and was "wrong and should be reversed." U.S. *Amicus* Br. 11-12, *Coventry Health Care of Mo., Inc.* v. *Nevils*, No. 13-1305 (U.S. May 22, 2015) ("U.S. Invitation Br."). At the government's suggestion, however, this Court gave the Missouri court a second chance, remanding for further consideration in light of a then-recent OPM regulation addressing the preemption issue, which the government hoped would steer the state court to "reach a different outcome" and resolve the split. *Id.* at 21; *see* 135 S. Ct. 2886 (2015).

That solution, regrettably, did not succeed. The split, in fact, has expanded and become entrenched, and the Missouri Supreme Court only exacerbated its errors. Since this Court's remand in this case, the Tenth Circuit and Arizona Court of Appeals have joined the Eighth Circuit—which has also reiterated its prior, pro-preemption interpretation—and the Georgia Supreme Court (among others) in rejecting the Missouri court's narrow view of FEHBA's preemptive scope. Indeed, FEHBA now has a different reach in Missouri in federal versus state courts.

Meanwhile, the Missouri Supreme Court strayed further from this Court's teaching. On remand, a five-judge majority not only declined to revisit the court's prior, erroneous reading of the statute, but also refused to accord any weight to OPM's reasonable position in its regulation—decreeing *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), categorically inapplicable to express-preemption provisions. And an even larger majority, creating a second lower-court conflict, held (in a precedential six-judge concurrence) that FEHBA's preemption provision is *unconstitutional*.

The need for definitive guidance is thus now even clearer. There is no prospect that the split will resolve itself. Even as more federal and state courts have rejected its reading of FEHBA, the Missouri Supreme Court has dug in, spurning the opportunity to reconsider its statutory interpretation. The court made clear, moreover, that it will not budge from its conclusion that *Chevron* never applies to express-preemption provisions unless told otherwise directly by this Court. This Court, in fact, has already rejected that misguided conclusion, but the Show-Me State insists on being shown again.

The Missouri Supreme Court's further holding striking down FEHBA's preemption provision *in toto* makes the need for intervention even more urgent. Left standing, the decision below will make operation of FEHBA plans in Missouri unworkable, inviting state law to trump *any* provision of OPM's contracts with FEHBA carriers, even those indisputably within FEHBA's preemption provision.

Both the Missouri Supreme Court's erroneous holdings and the splits they cement, regarding a nationwide program designed to operate seamlessly across state lines, cannot be allowed to persist. Congress enacted FEHBA's preemption clause precisely to prevent state laws from foisting inconsistent requirements on multi-State plans—recognizing that disuniformity increases the costs of administering FEHBA plans and unfairly forces federal workers in some States effectively to subsidize the benefits of those who live in others. Only this Court can restore uniformity and certainty to this critically important area of federal law.

The petition should be granted.

1. Congress enacted FEHBA in 1959, creating the Federal Employees Health Benefits Program (the "Program") to provide health-insurance benefits for the federal workforce. Congress sought to "assure maximum health benefits for [federal] employees at the lowest possible cost to themselves and to the Government." H.R. Rep. No. 86-957, at 4 (1959). Congress authorized OPM to administer the Program—including by issuing regulations, 5 U.S.C. § 8913(a), and by entering into contracts with private insurance carriers to administer FEHBA plans, *id.* § 8902(a).

Today, the FEHBA Program is "the largest employer-sponsored health benefits program in the United States." Press Release, OPM, *Open Season for Federal Health Benefits, Dental and Vision* (Sept. 29, 2015), http://tinyurl.com/hchvdub. It covers "[a]pproximately 85 percent of all Federal employees," *ibid.*—more than 8 million federal workers and dependents combined—and pays out tens of billions of dollars in benefits annually. OPM, *Final Rule, Federal Employees Health Benefits Program; Subrogation and Reimbursement Recovery*, 80 Fed. Reg. 29,203, 29,203 (May 21, 2015). The federal government (and ultimately the public) pays the lion's share of premiums (typically 72%)—more than $30 billion each year—and participants pay the remainder. *Ibid.*; 5 U.S.C. § 8906(b)(1).

2. In the 1970s, Congress became concerned about state regulation of FEHBA plans, which had "[i]ncreased premium costs to both the Government and enrollees" and introduced "[a] lack of uniformity of benefits" even "for enrollees in the same plan." H.R. Rep. No. 94-1211, at 3 (1976). "[E]nrollees in some States" were forced to pay "a premium based, in part, on the cost of benefits provided only to enrollees in *other* States." *Ibid.* (emphasis added). Congress responded in 1978 by enacting an express-preemption provision, which originally provided:

> The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that

> such law or regulation is inconsistent with such contractual provisions.

5 U.S.C. § 8902(m)(1) (1994).

After decades of additional experience, Congress concluded that this provision did not go far enough. It accordingly amended Section 8902(m)(1) in 1998 to "strengthen the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live," and to "prevent carriers' cost-cutting initiatives from being frustrated by State laws." H.R. Rep. No. 105-374, at 9 (1997). The amendments broadened Section 8902(m)(1), by adding language to preempt state laws that frustrate FEHBA-contract terms that relate to the "provision" of coverage, benefits, or benefit payments, and by removing the proviso limiting preemption to state laws "inconsistent" with FEHBA contracts. Pub. L. No. 105-266, § 3(c), 112 Stat. 2363, 2366 (1998).

3. OPM's FEHBA contracts have long included provisions requiring carriers to seek subrogation and reimbursement. *E.g.*, Standard Contract for Community-Rated Health Maintenance Organization Carriers § 2.5 (2000), *available at* http://tinyurl.com/joeb6dc. Such provisions apply where a beneficiary receives federal benefits under her FEHBA plan, but also recovers, or has a right to recover, for the same injuries from a third party. If the beneficiary has not yet recovered from the third party, the carrier must seek to recover from that party directly. If the beneficiary has already recovered, the carrier must seek reimbursement from the beneficiary. OPM, *Proposed Rule, Federal Employees Health Benefits Program; Subrogation and Reimbursement Recovery*, 80 Fed. Reg. 931, 932 (Jan. 7, 2015).

OPM has understood Section 8902(m)(1) "since Congress enacted it in 1978" to preempt state laws that would otherwise bar FEHBA carriers from seeking subrogation or reimbursement. *Final Rule*, 80 Fed. Reg. at 29,204; Pet. App. 117a-18a. OPM's contracts thus generally provide that carriers' subrogation and reimbursement obligations apply regardless of whether state law otherwise bars subrogation or reimbursement, so long as the carrier subrogates for one or more private employee-benefit plans governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* *See, e.g.*, Pet. App. 129a-30a. This ensures that FEHBA plans receive equal treatment with private-sector plans governed by ERISA, which this Court has held preempts state laws that preclude insurance administrators from seeking reimbursement. *See FMC Corp.* v. *Holliday*, 498 U.S. 52, 58-60 (1990).

4. Respondent Jodie Nevils commenced this putative state-court class action against Coventry, challenging Coventry's pursuit of subrogation and reimbursement as contrary to Missouri law. Nevils, a federal employee and FEHBA-plan participant, was injured in a car accident, and Coventry paid for his care. Pet. App. 45a. Nevils obtained a settlement recovery from the third party responsible for his injuries. *Ibid.* Coventry's OPM contract "direct[ed] [it] to seek reimbursement or subrogation when an insured obtains a settlement or judgment against a tortfeasor for payment of medical expenses." *Ibid.*; *id.* at 129a-30a. Coventry accordingly asserted (through a subcontractor) a lien on Nevils's settlement proceeds. *Id.* at 45a.

Nevils satisfied the lien but sued Coventry in Missouri state court, alleging that, notwithstanding

Coventry's OPM contract, Coventry's pursuit of subrogation or reimbursement violated Missouri's common-law antisubrogation doctrine. Pet. App. 45a. After Coventry unsuccessfully sought removal to federal court, the state trial court granted summary judgment for Coventry, holding that FEHBA preempts Nevils's claims. *Ibid.* Nevils appealed, and the court of appeals affirmed, agreeing with Coventry—and the United States, which participated as *amicus*—that FEHBA preempts Missouri's antisubrogation law. *Id.* at 36a-43a.

5. Nevils sought discretionary review in the Missouri Supreme Court to decide "[w]hether Missouri's anti-subrogation rule prohibiting an insurer from seeking reimbursement for benefits paid to its insured" is "preempted by 5 U.S.C. § 8902(m)(1)," which Nevils described as "an issue of great consequence to thousands of Missourians." Coventry Mo. S. Ct. Br. App. A.396 (Nov. 16, 2015) ("Coventry Remand Br."). The Missouri Supreme Court accepted the appeal and, in 2014, reversed in a divided decision (*Nevils I*). Pet. App. 46a-54a.

Disagreeing with Coventry, the United States, and multiple federal and state courts, *Nevils I* held that Section 8902(m)(1) does not preempt state antisubrogation and antireimbursement laws. Pet. App. 46a-54a. The court reasoned that the presumption against preemption and *Empire HealthChoice Assurance, Inc.* v. *McVeigh*, 547 U.S. 677 (2006)—which addressed federal-court *jurisdiction* over FEHBA reimbursement suits—require a narrow interpretation of Section 8902(m)(1). Pet. App. 47a-51a. The court also relied on *Kobold* v. *Aetna Life Insurance Co.* (*Kobold I*), 309 P.3d 924, 926-29 (Ariz. Ct. App. 2013), *review denied*, No. CV-13-299-PR (Ariz. Mar.

21, 2014), adopting *Kobold I*'s view that subrogation and reimbursement do not "relate to ... benefits" because they do not affect the amount of benefits participants are initially entitled to receive, but affect only participants' "net financial position after the provision of insurance benefits." Pet. App. 51a-53a.

Judge Wilson, joined by now-Chief Justice Breckenridge, concurred in the judgment. Pet. App. 55a-72a (Wilson, J., concurring in result). The concurring judges "disagree[d]" with the majority's statutory interpretation, concluding that Section 8902(m)(1) plainly evinces Congress's intent to preempt antisubrogation and antireimbursement laws. *Id.* at 55a-56a, 59a-66a. In their view, however, Section 8902(m)(1) violates the Constitution's Supremacy Clause, by purportedly giving preemptive effect to contractual provisions. *Id.* at 66a-72a.

6. Coventry sought certiorari, and this Court invited the United States' views. 135 S. Ct. 323 (2014). While Coventry's petition was pending, OPM proposed a regulation "reaffirm[ing]" OPM's longstanding position that FEHBA does preempt antisubrogation and antireimbursement laws because subrogation and reimbursement do "relate to the nature, provision and extent of coverage or benefits and benefit payments." *Proposed Rule*, 80 Fed. Reg. at 931-32. After receiving and reviewing comments, OPM promulgated a final rule in May 2015 codifying that position. *Final Rule*, 80 Fed. Reg. at 29,205 (codified at 5 C.F.R. § 890.106(h)).

The United States thereafter filed its invited brief, explaining that "[t]he decisio[n] of the Missouri Supreme Court" in *Nevils I* was "wrong, decide[d] an important and recurring question of federal law, ... open[ed] a conflict with decisions of other

state and federal courts on the same preemption question," and "should be reversed." U.S. Invitation Br. 11-12. The United States urged granting certiorari, vacating the Missouri Supreme Court's decision, and remanding in light of OPM's regulation. *Id.* at 20-21. OPM's interpretation of FEHBA, the government explained, is "entitled to the full measure of deference under *Chevron*," and the government perceived "a reasonable likelihood that the state cour[t] will conclude that OPM's regulations alter the outcome." *Id.* at 11-12, 22. The government urged the same course in *Kobold I*, in which the Court had also invited the government's views. *Ibid.*

Adopting the government's suggestion, this Court granted, vacated, and remanded in this case and *Kobold I* "for further consideration in light of [the] new regulations promulgated by [OPM]." 135 S. Ct. at 2886.

7. On remand, Coventry urged the Missouri Supreme Court to revisit its reading of FEHBA, but the court declined to do so. Instead, the principal opinion (for five of seven judges) addressed only whether OPM's regulation warranted a new result. Pet. App. 4a-13a. The court held that it did not, expressly refusing to accord any weight to OPM's interpretation. *Ibid.*

The court below asserted that *this* Court "has never held expressly that *Chevron* deference applies to resolve ambiguities in a preemption clause," and, "[a]bsent binding precedent requiring such deference," the Missouri Supreme Court would not defer. Pet. App. 5a, 8a-12a. Instead, it again applied a presumption against preemption. *Id.* at 6a-8a. And it expressly "decline[d] to follow" both the Arizona Court of Appeals' decision on remand—which re-

versed course and concluded that OPM's regulation is entitled to *Chevron* deference and "dispositive" on the preemption question, *Kobold* v. *Aetna Life Ins. Co.* (*Kobold II*), 370 P.3d 128, 130-32 (Ariz. Ct. App. 2016), *petition for review filed*, No. CV-16-0082-PR (Ariz. June 1, 2016)—and *Helfrich* v. *Blue Cross & Blue Shield Ass'n*, 804 F.3d 1090, 1109-10 (10th Cir. 2015), which held that OPM's interpretation is "persuasive" regardless of whether it is entitled to *Chevron* deference. Pet. App. 12a.

Judge Wilson again concurred only in the judgment—joined (as before) by Chief Justice Breckenridge, and now by four other members of the court who also joined the principal opinion. Pet. App. 14a (Wilson, J., joined by Breckenridge, C.J., and Fischer, Stith, Draper, and Russell, JJ., concurring in result); *id.* at 13a. Those six judges opined that, "for all the reasons stated in" Judge Wilson's "separate opinion" in *Nevils I*, Section 8902(m)(1) "is not a valid application of the Supremacy Clause," and therefore "does not displace Missouri law," because it purportedly "give[s] preemptive effect to the provisions of a contract between the federal government and a private party." *Id.* at 14a.

REASONS FOR GRANTING THE PETITION

The decision below solidifies an existing conflict regarding the interpretation of a federal statute that affects millions of federal workers, and creates a second split concerning the constitutionality of that statute. Both holdings contravene this Court's teaching and jeopardize the uniform, fair, and cost-efficient operation of a vital federal program.

The Missouri Supreme Court's holding that Congress intended to allow States to nullify subrogation

and reimbursement terms of FEHBA contracts cements the split extant when this Court vacated the Missouri court's prior ruling. The decision below directly conflicts with decisions of the Eighth Circuit—meaning state and federal courts in Missouri now disagree—as well as (*inter alia*) the Tenth Circuit, Georgia Supreme Court, and Arizona Court of Appeals. The Missouri court's reading of FEHBA is also irreconcilable with *this* Court's precedent. These conflicts concerning the construction of a federal statute amply justify plenary review.

The Missouri Supreme Court's additional determination—in a precedential concurrence joined by six of seven judges—that FEHBA's preemption provision is *unconstitutional* magnifies the need for this Court's intervention. That holding opens a new rift with every other court to consider the question, all of which have rejected the assertion that Section 8902(m)(1) violates the Supremacy Clause. It also badly misreads the statute. FEHBA itself supersedes certain state laws to make room for particular federal contracts to operate unimpeded; the statute simply refers to those contracts to delineate the scope of state law that *Congress* preempted. The Missouri Supreme Court's contrary view would leave Section 8902(m)(1) a dead letter—inviting States to nullify *any* provision of OPM's FEHBA contracts—and would place in grave peril multiple other federal statutes that define the scope of preemption in the same manner, including other federal-employee benefits statutes, ERISA, and the Federal Arbitration Act.

The stakes of both questions presented are staggering, as the United States' submissions in this Court and below make clear. The decision below

threatens to disrupt a multibillion-dollar federal program that serves millions of workers and dependents. And it would yield the very disuniformity, unfairness, and cost-inefficiency that Congress enacted Section 8902(m)(1) to avoid. This case provides the perfect opportunity to resolve these undeniably important questions and to restore clarity and uniformity to this highly significant area of federal law.

I. THE MISSOURI SUPREME COURT'S READING OF FEHBA'S PREEMPTION CLAUSE CEMENTS A LOWER-COURT SPLIT AND CONTRAVENES THE STATUTE AND THIS COURT'S PRECEDENT.

The Missouri Supreme Court's interpretation of Section 8902(m)(1)'s preemptive scope entrenches a conflict with multiple federal and state courts. And it cannot be reconciled with FEHBA's text and purpose or this Court's case law.

A. The Decision Below Conflicts With Multiple Federal And State Courts' Rulings Construing Section 8902(m)(1).

Every appellate court besides the Missouri Supreme Court to address the issue agrees that Section 8902(m)(1) preempts antisubrogation and antireimbursement laws—based either on the statute alone or deference to OPM's reading, now codified in its regulation. The Missouri Supreme Court has twice rejected that consensus view, and both its result and reasoning contradict other courts' decisions.

1. The Eighth Circuit has twice held that Section 8902(m)(1) preempts antisubrogation and antireimbursement laws. In *MedCenters Health Care* v. *Ochs*, 26 F.3d 865 (8th Cir. 1994), *abrogated on other grounds by McVeigh*, 547 U.S. 677—long before OPM's regulation—it held that Section 8902(m)(1)

preempted a state law that purported to prevent a FEHBA carrier from seeking subrogation under its OPM contract. *Id.* at 867.

The Eighth Circuit reaffirmed that holding earlier this year in *Bell* v. *Blue Cross & Blue Shield of Oklahoma*, __ F.3d __, 2016 WL 3027487 (8th Cir. May 26, 2016). Expressly "disagree[ing]" with the decision below, *Bell* held that, "[e]ven without deference to the agency under *Chevron*, the better reading of the statute's text" is that "reimbursement and subrogation provisions ... restrict the payment of benefits," and so "relate to 'benefits (including payments with respect to benefits)'" under Section 8902(m)(1). *Id.* at *4-5. *Bell* rejected the contention that the presumption against preemption compels a narrower reading of Section 8902(m)(1): Given the "obviously ... long history of federal involvement in federal employment and benefits," and the "'considerable,'" "'[d]istinctly federal interests'" in the operation of "a *federal* health insurance plan for *federal* employees that arise from a *federal* law," the court found "no warrant to place a thumb on the scales against preemptive effect of the federal statute." *Id.* at *3 (emphases added) (citations omitted).

Other courts read Section 8902(m)(1) the same way based on their own analysis of the statute. In *Thurman* v. *State Farm Mutual Automobile Insurance Co.*, 598 S.E.2d 448 (Ga. 2004), for instance, the Georgia Supreme Court held—in determining whether a FEHBA participant could seek uninsured-motorist benefits from her automobile insurer—that Section 8902(m)(1) preempted a state law that otherwise would have prevented the FEHBA carrier from seeking subrogation. *Id.* at 449-51; *see also Shields* v. *Gov't Emps. Hosp. Ass'n*, 450 F.3d 643, 648

(6th Cir. 2006), *overruled on other grounds by Adkins* v. *Wolever*, 554 F.3d 650, 652 (6th Cir. 2009) (en banc); *NALC Health Benefit Plan* v. *Lunsford*, 879 F. Supp. 760, 762-63 (E.D. Mich. 1995); *Aybar* v. *N.J. Transit Bus Operations, Inc.*, 701 A.2d 932, 937-38 (N.J. App. Div. 1997).

2. Still other courts have adopted the same reading of FEHBA by according varying degrees of deference to OPM's long-settled interpretation.

In *Kobold II*—on remand from this Court—the Arizona Court of Appeals held, notwithstanding its prior interpretation of Section 8902(m)(1), that OPM's regulation construing FEHBA to preempt antisubrogation and antireimbursement laws is "entitled to *Chevron* deference" and thus "dispositive." 370 P.3d at 130. OPM's interpretation is "procedurally eligible for *Chevron* deference," the court held, because it is codified in a notice-and-comment regulation that OPM was statutorily authorized to promulgate. *Ibid.* (citing 5 U.S.C. § 8913(a)). And OPM's view "qualif[ies] substantively for *Chevron* deference" because it is not "unreasonable." *Id.* at 131. *Chevron* therefore "compel[led]" the Arizona Court of Appeals "to apply OPM's interpretation." *Ibid.* The court's conclusion that deference applies to OPM's interpretations of Section 8902(m)(1)'s preemptive scope accords with *Blue Cross & Blue Shield of Florida, Inc.* v. *Department of Banking & Finance*, 791 F.2d 1501 (11th Cir.) (per curiam), *reh'g denied*, 797 F.2d 982 (11th Cir. 1986), which deferred to OPM's "reasonable" position that Section 8902(m)(1) preempts state laws regulating unclaimed federal-benefit checks. *Id.* at 1506.

The Tenth Circuit in *Helfrich* likewise relied on OPM's interpretation in determining that Section

8902(m)(1) preempts antisubrogation and antireimbursement laws. 804 F.3d at 1109-10. *Helfrich* found it unnecessary to resolve whether *Chevron* or a "less deferential standard" drawn from *Skidmore* v. *Swift & Co.*, 323 U.S. 134 (1944), applies, "because even under the less deferential standard" the Tenth Circuit "would adopt OPM's conclusion." 804 F.3d at 1109-10 & n.11. Like the Eighth Circuit in *Bell*, the Tenth Circuit emphatically rejected application of a presumption against preemption to Section 8902(m)(1): "The federalism concern ... behind the presumption ... has little purchase" given the powerful federal interests in a program that "governs only contracts for the benefit of federal employees" and the long "'history of significant federal presence' in the area." *Id.* at 1105 (citation omitted); *see also Calingo* v. *Meridian Res. Co.*, 2013 WL 1250448 (S.D.N.Y. Feb. 20, 2013) (according significant weight to OPM's reading, then expressed in a guidance letter).

3. The decision below directly conflicts with the reasoning and results of all of these decisions. In its divided 2014 decision in *Nevils I*, the Missouri Supreme Court expressly disagreed with *Thurman* and other cases and held that Section 8902(m)(1) does not preempt antisubrogation and antireimbursement laws. Pet. App. 46a-54a. The majority rejected OPM's and other courts' interpretation of Section 8902(m)(1)'s text, instead relying heavily on the presumption against preemption that the Eighth and Tenth Circuits have held inapplicable. *Ibid.*

Although this Court vacated *Nevils I* and remanded for further consideration in light of OPM's 2015 regulation, on remand the Missouri Supreme Court doubled down. Unlike the Arizona Court of

Appeals in *Kobold II*—which did change course in response to OPM's regulation—the Missouri court held once again that Section 8902(m)(1) does not preempt antisubrogation and antireimbursement laws. Pet. App. 4a-13a. Every step of its reasoning, moreover, conflicts with other courts' rulings. On remand the court declined to revisit its analysis of the statutory text, which the Eighth Circuit and Georgia Supreme Court among others have rejected. It relied again on the presumption against preemption that the Eighth and Tenth Circuits have held inapplicable. Pet. App. 6a-8a. And the court refused to accord any weight to OPM's view—"declin[ing] to follow" the Tenth Circuit's and Arizona Court of Appeals' contrary decisions, and making clear that it will not change its view "[a]bsent binding precedent requiring" such deference. *Id.* at 5a, 12a.

The decision below thus solidifies a direct conflict concerning the preemptive scope of a federal statute applicable to millions of federal workers and dependents nationwide. Indeed, because the Eighth Circuit has since explicitly disagreed with the Missouri Supreme Court's 2014 decision and its ruling on remand, *see Bell*, 2016 WL 3027487, at *5, FEHBA's preemptive scope in Missouri now turns on whether cases proceed in federal or state court. That conflict between federal and state courts in the same State presents a particularly urgent reason for review. *See, e.g.*, *Johnson* v. *California*, 545 U.S. 162, 164 (2005); *Hagen* v. *Utah*, 510 U.S. 399, 409 (1994). Given the Missouri Supreme Court's refusal to revisit its position on remand despite OPM's regulation—and that court's line-in-the-sand pronouncement that it will continue to disregard the agency's interpretation until specifically instructed otherwise by *this*

Court—there is no realistic prospect that the split will resolve itself.

B. The Missouri Supreme Court's Reading Of Section 8902(m)(1) And Refusal To Defer To OPM Contradicts FEHBA And This Court's Precedent.

The Missouri Supreme Court's outlier interpretation of Section 8902(m)(1) misreads the statute and departs fundamentally from this Court's teaching.

1. Construing any "pre-emption provision begins 'with the language of the statute itself,'" "'which necessarily contains the best evidence of Congress's preemptive intent.'" *Puerto Rico* v. *Franklin Cal. Tax-Free Trust*, 136 S. Ct. 1938, 1946 (2016) (citation omitted). Where "'the statute's language is plain,'" that "'is also where the inquiry should end.'" *Ibid.* (citation omitted). If the text alone is not conclusive, courts must examine Congress's "purpose"—the "ultimate touchstone of pre-emption analysis." *Wis. Dep't of Ind., Labor & Human Relations* v. *Gould Inc.*, 475 U.S. 282, 290 (1986) (internal quotation marks omitted). The decision below disobeyed these commands.

a. Section 8902(m)(1) expressly "supersede[s]" state laws that frustrate "[t]he terms of any [FEHBA] contract ... which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)." 5 U.S.C. § 8902(m)(1). As this Court has "repeatedly recognized," "relates to" in a preemption clause "express[es] a broad pre-emptive purpose" with an "'expansive sweep.'" *Morales* v. *Trans World Airlines, Inc.*, 504 U.S. 374, 383-84 (1992) (citation omitted); *accord Northwest, Inc.* v. *Ginsberg*, 134 S. Ct. 1422,

1428 (2014). Thus construed, Section 8902(m)(1) comfortably encompasses antisubrogation and antireimbursement laws.

i. "Subrogation and reimbursement clauses" relate to employees' *benefits* because, by definition, they make payment of benefits "conditional upon a right to subrogation or reimbursement of equivalent amounts, either from a third-party, or from the enrollee, in the event a third party is obligated to pay for the same injury or illness." *Proposed Rule*, 80 Fed. Reg. at 932. Indeed, this Court has specifically held in the context of *private* employee-benefit plans governed by ERISA that reimbursement "relate[s] to" benefits, and thus to private benefit plans, such that antireimbursement laws are preempted by ERISA's strikingly similar preemption clause, 29 U.S.C. § 1144(a). *FMC*, 498 U.S. at 58-60.

The Missouri Supreme Court has twice held that subrogation and reimbursement do *not* "relate to ... benefits," Pet. App. 1a-2a, 4a-13a, 51a-54a, but it has never attempted to square that view with this Court's decisions construing "relate to" expansively or *FMC*'s interpretation of ERISA's parallel provision—all of which Coventry presented. Coventry Remand Br. 33-36. Nor is there any basis to construe FEHBA's "nearly identical ... preemption provision" more narrowly than ERISA. *Pharm. Care Mgmt. Ass'n* v. *Rowe*, 429 F.3d 294, 299-300 n.2 (1st Cir. 2005). Lower courts have repeatedly looked to ERISA case law in interpreting Section 8902(m)(1). *See, e.g., ibid.*; *Botsford* v. *Blue Cross & Blue Shield of Mont., Inc.*, 314 F.3d 390, 393-94 (9th Cir. 2002); *Aybar*, 701 A.2d at 935-36. And, as the government has explained, "[i]t is exceedingly unlikely that Congress intended a *broader* role for state law in the

case of federal employees than in the case of private employees, or that Congress desired *less* uniformity in the case of federal employees." Pet. App. 178a (emphases added).

The Missouri Supreme Court's only textual analysis further disregards this Court's teaching. The court's 2014 opinion in *Nevils I*—to which it adhered on remand, Pet App. 1a-2a—reasoned that subrogation and reimbursement do not "relate to ... benefits" because they do not affect the amount of benefits a participant is initially entitled to receive, but govern only what the participant must repay later. Pet. 52a-53a. That facile distinction is illusory: Regardless of the amount of benefits a FEHBA participant *initially* receives, subrogation and reimbursement rights directly affect how much the participant may *retain*.

This Court has emphatically rejected a similar, equally artificial distinction in the setting of federal employees' life insurance. In *Hillman* v. *Maretta*, 133 S. Ct. 1943 (2013), it held that a federal law prescribing who receives life-insurance payments impliedly preempted a state law directing recipients of life-insurance payments to *transfer* them to someone else. *Id.* at 1952. It "makes no difference," *Hillman* explained, whether a state law withholds benefits in the first instance or takes them away after they have been paid; "[i]n either case, state law displaces the beneficiary selected" by federal law, and so is preempted. *Ibid.* The Missouri Supreme Court's claim that reimbursement is irrelevant to benefits because it affects only whether the recipient may *keep* what she initially receives rings hollow.

The decision below also relied on dictum in *McVeigh* describing competing interpretations of

Section 8902(m)(1) as "plausible." 547 U.S. at 697-98; Pet. App. 3a, 49a. But *McVeigh*, which addressed only federal-court *jurisdiction* over FEHBA carriers' reimbursement actions, expressly reserved judgment on Section 8902(m)(1)'s scope because it made no difference there. 547 U.S. at 698 ("we need not choose between" proffered constructions). Even read for all it might be worth, *McVeigh*'s dictum hardly justifies declaring Section 8902(m)(1)'s words a wash, as the court below did. "[T]o acknowledge ambiguity is not to conclude that all interpretations are *equally* plausible." *Gwaltney of Smithfield, Ltd.* v. *Chesapeake Bay Found., Inc.*, 484 U.S. 49, 57 (1987) (emphasis added).

ii. The Missouri Supreme Court not only distorted the text it addressed, but it ignored another critical part of the text altogether. Regardless of whether subrogation and reimbursement relate to *benefits*, they certainly "relate to" the "*provision*" of "*payments with respect to* benefits," 5 U.S.C. § 8902(m)(1) (emphases added); *see Helfrich*, 804 F.3d at 1106. The whole point of subrogation and reimbursement is to *undo* or *reduce* prior benefit payments. Reimbursement requires the insured herself to return to the carrier the value of benefits previously provided. And subrogation requires the insured to surrender to the carrier her right to recover from the third party. 5 C.F.R. § 890.101(a).

Both in its original decision and on remand, the court below was presented with this independently dispositive text. Pet. App. 176a-77a; Coventry Remand Br. 38-40. Yet neither decision addressed it.

b. The Missouri Supreme Court's interpretation of Section 8902(m)(1) also thwarts Congress's purpose—which the court below never confronted. Con-

gress enacted Section 8902(m)(1) to address concerns that state laws mandating the benefits FEHBA plans offer would cripple uniformity and make administration of nationwide plans unmanageable. S. Rep. No. 95-903, at 7-8 (1978); H.R. Rep. No. 95-282, at 3-7 (1977); H.R. Rep. No. 94-1211, at 3. Congress later *broadened* Section 8902(m)(1) "to strengthen the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live," and to "prevent carriers' cost-cutting initiatives from being frustrated by State laws." H.R. Rep. No. 105-374, at 9.

Construing Section 8902(m)(1) to supersede anti-subrogation and antireimbursement laws "furthers Congress's goals of reducing health care costs and enabling uniform, nationwide application of FEHB contracts." *Final Rule*, 80 Fed. Reg. at 29,203. It also advances the "strong federal interest in national uniformity in coverage and benefits," which "include[s] uniform administration of the FEHB program across state lines." *Proposed Rule*, 80 Fed. Reg. at 932.

In contrast, allowing state laws to block carriers from seeking subrogation and reimbursement defeats Congress's objectives. As the government has explained, "Missouri's anti-subrogation rule is indistinguishable from the state mandated-benefit laws that Congress expressly targeted with the enactment of the FEHBA preemption provision," as it "requires FEHB providers to provide Missouri consumers with FEHB benefits that consumers in other states do not receive under the terms of the same FEHB contract." Pet. App. 179a. "If Missouri's anti-subrogation rule survives preemption, the loser will be FEHB enrollees in states that permit subrogation, who will be

subsidizing the more generous benefits that Missouri law effectively mandates that FEHB carriers provide to Missouri residents"—"creat[ing] precisely the disuniformity that Congress intended to preclude," and undermining Congress's goal of facilitating carriers' cost-cutting efforts. *Ibid.*

Indeed, as the United States and Coventry showed below, antisubrogation and antireimbursement laws pose such an "'obstacle to the accomplishment and execution of the full purposes and objectives of Congress'" that they would be impliedly preempted even if Section 8902(m)(1) did *not* apply. Pet. App. 180a (quoting *Arizona* v. *United States*, 132 S. Ct. 2492, 2505 (2012)); Coventry Remand Br. 43-45; *see also Hillman*, 133 S. Ct. at 1949-55 (holding state law impliedly preempted by federal-employee life-insurance statute without addressing express preemption). Congress's purposes in enacting that express-preemption provision confirm that it encompasses such laws.

2. The Missouri Supreme Court compounded its error by refusing to defer to OPM's reasonable interpretation. Under *Chevron*, an agency's reading of a statute it administers, expressed in a notice-and-comment regulation, "governs if it is a reasonable interpretation of the statute"—regardless of whether it is "the only possible interpretation" or "even the interpretation deemed *most* reasonable by the courts." *Entergy Corp.* v. *Riverkeeper, Inc.*, 556 U.S. 208, 218 (2009). This rule applies to "*all* the matters the agency is charged with administering." *City of Arlington* v. *FCC*, 133 S. Ct. 1863, 1874 (2013).

Chevron required the court below to defer to OPM's regulation interpreting FEHBA to preempt antisubrogation and antireimbursement laws. Con-

gress expressly authorized OPM to issue regulations administering FEHBA. 5 U.S.C. § 8913(a). Even if other readings of Section 8902(m)(1) were also permissible, OPM's reading is at least reasonable. The decision below itself conceded that OPM's reading is "plausible." Pet. App. 3a.

The Missouri Supreme Court nevertheless refused to accord OPM's view any weight. It asserted that *Chevron* is categorically inapplicable to express-preemption provisions, and that this "Court has never held expressly that *Chevron* deference applies to resolve ambiguities in a preemption clause." Pet. App. 5a, 8a-12a. That is wrong.

This Court has flatly rejected the assertion that *Chevron* applies piecemeal to some topics under a statute an agency administers but not others. *City of Arlington*, 133 S. Ct. at 1874. Where an agency is authorized to interpret a statute, "the whole includes all of its parts"; *Chevron* applies to them all. *Ibid.* That principle applies with full force to an agency's interpretation of the "meaning" of a provision that "pre-empts state law." *Smiley* v. *Citibank (S.D.), N.A.*, 517 U.S. 735, 744 (1996).

Indeed, this Court has held that, even independent of an express-preemption provision, regulations issued by an agency acting within its rulemaking authority "'have no less pre-emptive effect than federal statutes,'" for "'[w]here Congress has directed an administrator to exercise his discretion, his judgments are subject to judicial review only to determine whether he has exceeded his statutory authority or acted arbitrarily.'" *Capital Cities Cable, Inc.* v. *Crisp*, 467 U.S. 691, 699 (1984) (citation omitted). Thus, even without "'express congressional authorization to displace state law,'" "if the agency's choice

to pre-empt 'represents a reasonable accommodation of conflicting policies that were committed to the agency's care by the statute, [courts] should not disturb it unless it appears from the statute or its legislative history that the accommodation is not one that Congress would have sanctioned.'" *City of New York* v. *FCC*, 486 U.S. 57, 64 (1988) (citation omitted). *A fortiori*, where Congress *has* expressly preempted some state laws, the agency's reasonable interpretation of the scope of that preemption deserves deference.

Applying this principle, this Court has repeatedly deferred to agency interpretations of statutes that preempt state law. *Smiley*, for example, expressly held that *Chevron* required deferring to the Comptroller of the Currency's reasonable view of the scope of a statute (12 U.S.C. § 85) that this Court had already determined "pre-empts state law." 517 U.S. at 743-45. The Missouri Supreme Court perplexingly read *Smiley* to *preclude* deference, Pet. App. 9a-10a; that reading is backwards. *Smiley* distinguished "the question of the substantive (as opposed to pre-emptive) *meaning* of a statute with the question of *whether* a statute is pre-emptive" at all. 517 U.S. at 744. *Smiley* "assume[d] (without deciding) that the latter question"—whether a statute preempts *anything*—is not subject to *Chevron*. *Ibid.* But *Smiley* held that, where "there is no doubt" that the statute preempts *some* state laws, *Chevron* applies with full force to the agency's reasonable interpretation of *which* state laws. *Ibid.*

The decision below also ignored or distorted this Court's later decisions confirming this principle. In *Medtronic, Inc.* v. *Lohr*, 518 U.S. 470, 496-97 (1996)—the relevant holding of which the decision

below never addressed—this Court deferred to a Food and Drug Administration regulation construing the scope of an express-preemption provision regarding medical devices, 21 U.S.C. § 360k(a). And *Cuomo* v. *Clearing House Ass'n, LLC*, 557 U.S. 519 (2009), held that "the familiar *Chevron* framework" applied to an express-preemption provision, and declined to defer only because the "outer limits" of the statute were "clear" and the agency's reading strayed beyond those "bounds." *Id.* at 525. The Missouri Supreme Court misread *Clearing House* as deeming *Chevron* irrelevant, Pet. App. 11a-12a—an error this Court's opinion refutes.

The Missouri Supreme Court thus had no warrant to "declin[e]" to defer (Pet. App. 5a) to OPM's regulation. At a minimum, it was obliged to give respectful consideration to the "longstanding and persuasively explained" view of OPM—which, "[a]s the agency that has negotiated FEHBA contracts for federal employees for years, ... has deep knowledge of the impact and interrelationships of contractual provisions." *Helfrich*, 804 F.3d at 1109-10; *see Kasten* v. *Saint-Gobain Performance Plastics Corp.*, 131 S. Ct. 1325, 1335-36 (2011). The Missouri Supreme Court's refusal to accord OPM's reading any weight flouts this Court's case law.

3. The interpretive principle the decision below substituted for *Chevron* further contradicts this Court's precedent. Instead of "presum[ing]" that Congress desired any "ambiguity" to "be resolved, first and foremost, by the agency," *Smiley*, 517 U.S. at 740-41, the decision below applied a presumption against preemption. Pet. App. 6a-8a. But this Court's case law makes clear that the presumption is inapplicable to Section 8902(m)(1), and in any event

cannot overcome Congress's clearly evinced intent or OPM's reasonable position.

The presumption against preemption is irrelevant at the outset because Section 8902(m)(1) *expressly* preempts state law. Where a "statute contains an express pre-emption clause," this Court has held, courts should "*not* invoke any presumption against pre-emption," but should "instead focus on the plain wording of the clause." *Franklin*, 136 S. Ct. at 1946 (emphasis added) (internal quotation marks omitted).

Moreover, the presumption "is not triggered" in areas "where there has been a history of significant federal presence," *United States* v. *Locke*, 529 U.S. 89, 108 (2000), or where the "interests at stake are 'uniquely federal' in nature," *Buckman Co.* v. *Plaintiffs' Legal Comm.*, 531 U.S. 341, 347 (2001) (citation omitted); *see also Gobeille* v. *Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 946 (2016). *Both* are true of the provision of benefits to federal employees. *See Bell*, 2016 WL 3027487, at *2-4; *Helfrich*, 804 F.3d at 1104-06. Contracts "concer[ning] benefits from a *federal* health insurance plan for *federal* employees that arise from a *federal* law" implicate "'[d]istinc[t] *federal* interests.'" *Bell*, 2016 WL 3027487, at *3, *5 (emphases added) (citation omitted). Even the court below acknowledged the "strong federal interest" at stake. Pet. App. 12a. And it is "an understatement to say that 'there has been a history of significant *federal* presence' in the area of *federal* employment." *Helfrich*, 804 F.3d at 1105 (emphases added) (citation omitted). There is thus no reason to assume that, in enacting (and expanding) FEHBA's preemption provision, Congress intended to tread lightly.

In any event, the presumption against preemption could not overcome FEHBA's clear text and purpose, or OPM's position. Even "state laws 'governing'" issues of paradigmatic state concern—such as "family law"—"'must give way to clearly conflicting federal enactments.'" *Hillman*, 133 S. Ct. at 1950 (citation omitted). And even if Section 8902(m)(1)'s text were ambiguous, this Court has made clear that the presumption against preemption does not "trum[p] *Chevron*." *Smiley*, 517 U.S. at 743-44. Because OPM's reading merits *Chevron* deference, the presumption never comes into play. *See ibid.*; *New York* v. *FERC*, 535 U.S. 1, 18 (2002).

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The decision below yields an intractable lower-court conflict. And its interpretation of FEHBA's preemption provision flouts Congress's direction and this Court's teaching at every turn. Only this Court can definitively resolve the split and conclusively resolve Section 8902(m)(1)'s proper scope.

II. THE MISSOURI SUPREME COURT'S HOLDING THAT FEHBA'S PREEMPTION CLAUSE IS UNCONSTITUTIONAL CREATES A FURTHER LOWER-COURT CONFLICT AND IS INCORRECT.

The decision below opened a second lower-court rift and exacerbated its errors by further concluding—in a six-judge concurrence that now governs in Missouri—that Section 8902(m)(1) is unconstitutional. That additional holding striking down an exceptionally important federal statute and the conflict it creates urgently warrant this Court's intervention.

A. The Decision Below Creates A Second, Direct Conflict Concerning Section 8902(m)(1)'s Constitutionality.

1. Until the decision below, federal and state courts consistently held that Section 8902(m)(1) comports with the Supremacy Clause. In *Empire HealthChoice Assurance, Inc.* v. *McVeigh*, 396 F.3d 136 (2d Cir. 2005) (Sotomayor, J.), *aff'd*, 547 U.S. 677, the Second Circuit directly addressed the concern that, if Section 8902(m)(1) were construed to give preemptive effect to something *other* than federal laws, it would violate the Supremacy Clause. *Id.* at 143-44. As the Second Circuit explained, that concern is easily resolved by "reasonably construing" Section 8902(m)(1) "as requiring that, in cases involving the 'terms of any contract under FEHBA which relate to the nature, provision, or extent of coverage or benefits,' *federal law* 'shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.'" *Id.* at 144 (citation and brackets omitted). Even the dissent agreed on this point. *Id.* at 156 (Raggi, J., dissenting).

Other courts since have agreed. In *Bell*, after noting that the plaintiff failed to challenge Section 8902(m)(1)'s constitutionality below, the Eighth Circuit rejected that challenge. 2016 WL 3027487, at *5 (finding "no obvious error that warrants correction on appeal"). Expressly disagreeing with the six-judge concurrence in this case, *Bell* adopted the Second Circuit's view that "the statute can reasonably be construed to mean that federal law ... , not the contractual terms, has the preemptive force," obviating any Supremacy Clause concern. *Ibid.* Likewise, in *Kobold II*, the Arizona Court of Appeals held that

Section 8902(m)(1) does not violate the Supremacy Clause. 370 P.3d at 131 n.2. "FEHBA contract terms," it explained, are "circumscribed by the terms of the FEHBA and the standards prescribed by the OPM," which by regulation *requires* FEHBA contracts to include subrogation and reimbursement clauses. *Ibid.*

2. A supermajority of the Missouri Supreme Court here, however, struck down Section 8902(m)(1) as a violation of the Supremacy Clause. In *Nevils I*, Judge Wilson (joined by now-Chief Justice Breckenridge), while rejecting the majority's statutory interpretation, opined that Section 8902(m)(1) was inoperative because it violates the Supremacy Clause—expressly disagreeing with "the saving construction offered by then-Judge Sotomayor" in *McVeigh*. Pet. App. 70a. On remand, Judge Wilson—joined again by Chief Justice Breckenridge *and* by four additional judges, *id.* at 13a—adhered to that view. *Id.* at 14a. Those six judges opined that, "for all of the reasons stated in" Judge Wilson's prior "separate opinion," Section 8902(m)(1)'s "attempt to give preemptive effect to the provisions of a contract between the federal government and a private party is not a valid application of the Supremacy Clause." *Ibid.*

That constitutional determination by a majority of the Missouri Supreme Court—by more judges than joined the lead opinion—is now controlling in Missouri state courts. Under Missouri law, a "concurring opinion" in which "a majority of the court concur[s]" is binding precedent. *Mueller* v. *Burchfield*, 224 S.W.2d 87, 89 (Mo. 1949) (holding that concurrence "overruled" prior precedent). That is true even where, as here, the concurrence's rationale is broader than that of the principal opinion. *See State*

ex rel. Bothwell v. *Green*, 180 S.W.2d 12, 13 (Mo. 1944) (holding that prior concurring opinion had "overruled" earlier precedent, even though principal opinion had "attempted to distinguish" that precedent). Missouri courts now are bound to conclude in future cases that Section 8902(m)(1) has *no* preemptive effect, even as to issues that indisputably "relate" to coverage or benefits, because under the decision below that federal statutory provision is entirely invalid.

B. The Missouri Supreme Court's Holding That Section 8902(m)(1) Violates The Supremacy Clause Is Wrong.

The concurrence's precedential determination that Section 8902(m)(1) is unconstitutional is incorrect and rests on a fundamental misunderstanding of the statute. FEHBA does not, as the concurring judges asserted, make contract terms themselves preempt state law. As the Second Circuit and other courts have explained, it is Section 8902(m)(1) *itself* that declares the state laws it covers "'supersede[d] and preempt[ed].'" *McVeigh*, 396 F.3d at 144-45 (quoting 5 U.S.C. § 8902(m)(1)). FEHBA simply defines the scope of preemption by reference to a class of federal contracts. What matters is that *Congress*, by enacting a statute—one of "the Laws of the United States," U.S. Const. art. VI, cl. 2—prescribed the existence and scope of preemption; that is all the Supremacy Clause requires. Even if Section 8902(m)(1) could be read differently, it certainly *can* (and therefore must) be read in this sensible fashion, which averts any constitutional concern. *See Edward J. DeBartolo Corp.* v. *Fla. Gulf Coast Bldg. & Constr. Trades Council*, 485 U.S. 568, 575 (1988).

This aspect of FEHBA's preemption provision, in fact, is unremarkable. Congress can and does define the scope of preemption in a variety of ways—sometimes preempting all laws on a topic, *see, e.g.*, *Morales*, 504 U.S. at 383 (addressing 49 U.S.C. App. § 1305(a)(1)); sometimes preempting only state laws that contradict or add to particular federal requirements, *see, e.g.*, *Riegel* v. *Medtronic, Inc.*, 552 U.S. 312, 316 (2008) (applying 21 U.S.C. § 360k(a)); and sometimes preempting an area of state law defined by reference to particular contracts—as it did in FEHBA, 5 U.S.C. § 8902(m)(1), as well as other federal benefits statutes, *id.* §§ 8709(d)(1), 8959, 8989, 9005(a); 10 U.S.C. § 1103(a), the Federal Arbitration Act, 9 U.S.C. § 2, and ERISA, 29 U.S.C. § 1144(a).

If Congress (as no one disputes) can enact the first two types of preemption clauses, there is no reason, and the decision below offered none, why it cannot enact the third. Such laws, including FEHBA, pass constitutional muster because *Congress* defined the scope of preemption in a duly enacted law. The decision below, however, would call the validity of all federal statutes that link the scope of preemption to contracts or other instruments into grave doubt.

III. This Case Is An Excellent Vehicle To Resolve The Important And Recurring Questions Of The Scope And Validity Of FEHBA's Preemption Clause.

The statutory and constitutional questions this case presents are indisputably important. This case provides an ideal opportunity to answer them.

A. As the United States and Nevils each have noted, "whether States can prohibit subrogation under a FEHB contract" is "important." U.S. Invitation

Br. 17; *accord* Coventry Remand Br. App. A.396 (Nevils arguing that question presented is "an issue of great consequence"). The FEHBA Program provides tens of billions of dollars in benefits to millions of federal workers and dependents each year. *Final Rule*, 80 Fed. Reg. at 29,203. "Subrogation recoveries translate to premium cost savings" for those participants and for taxpayers. *Ibid.* By allowing States to forbid such recoveries, the decision below will greatly increase the Program's costs. And it puts FEHBA carriers—which are contractually *required* to seek subrogation and reimbursement, U.S. Invitation Br. 4—to an untenable choice between fulfilling their duties to OPM and obeying state law.

The decision below compounds these problems by permitting each State to apply its own requirements. "Most FEHB enrollees receive benefits under nationwide plans[.]" Pet. App. 179a. Without preemption, carriers thus must navigate an "'administratively burdensome'" labyrinth of diverse state-law rules that "'gives rise to uncertainty and litigation.'" U.S. Invitation Br. 15 (citation omitted); *see* Ass'n of Fed. Health Orgs., *State Laws Restricting Subrogation and Reimbursement* (2014), http://tinyurl.com/podatzj (summarizing patchwork of state subrogation laws). This disuniformity will also "resul[t] in unfairness and real-world financial harm to federal employees" by "creat[ing] a cross-subsidy problem": The decision below "effectively ... force[s]" FEHBA "[p]articipants who live in States that allow subrogation ... to cross-subsidize participants in the same plan who live in States that prohibit it." U.S. Invitation Br. 17.

The need for this Court's intervention is even greater now than when this case was last before the

Court. It was "precisely ... the importance of this question as a matter of federal policy" that prompted OPM to promulgate its regulation, which the government hoped would resolve the conflict. U.S. Invitation Br. 20-21. That effort, however, has failed. This Court gave the state courts in this case and *Kobold* an opportunity to modify their conclusions in light of the regulation, but the Missouri Supreme Court (unlike the Arizona court in *Kobold*) refused. It has made clear, moreover, that no further action by OPM will make any difference, based on the court's mistaken view that OPM's interpretation of FEHBA's preemptive scope deserves no deference. Plenary review by this Court is now the only option.

The Missouri Supreme Court's further holding striking down Section 8902(m)(1) as unconstitutional makes plenary review more urgent still. By holding that Section 8902(m)(1) preempts *nothing*, the decision below permits States to nullify *any* FEHBA-contract provision—even those that unquestionably "relate to" the "provision" of "coverage" or "benefits." Unless overturned, that ruling will make administration of FEHBA plans utterly impracticable in Missouri—and any State or Circuit that follows suit.

B. This Court can and should avert these grave harms by definitively resolving these statutory and constitutional questions. This case provides the perfect opportunity.

Both the statutory-interpretation and constitutional questions were thoroughly pressed and passed upon below. As the United States explained previously, the Missouri Supreme Court's 2014 decision "squarely present[ed] the preemption question." U.S. Invitation Br. 18. This Court remanded for the state court to reconsider that question with the benefit of

OPM's regulation, which the court below has now done, refusing to alter its position. Pet. App. 1a-2a. The question of Section 8902(m)(1)'s constitutionality was also thoroughly litigated in the Missouri Supreme Court, which in a precedential concurrence squarely addressed it. *Id.* at 14a (Wilson, J., concurring in result). The concurrence leaves no doubt that, if this Court were to reverse only the state court's statutory interpretation, the Missouri Supreme Court will continue to deem Section 8902(m)(1) a nullity.

The applicability and validity of FEHBA's preemption provision is also outcome-determinative. The state trial court granted, and the court of appeals affirmed, summary judgment for Coventry based on their conclusion that FEHBA forecloses Nevils's state-law claim. If this Court reverses the decision below and holds that FEHBA's preemption provision is applicable and constitutional, Coventry will be entitled to judgment, and the case will end.

For the same reason, the decision below is "final" under 28 U.S.C. § 1257(a). "[T]he federal issue[s] ha[ve] been finally decided," "reversal of the state court on the federal issue would be preclusive of any further litigation," and "a refusal immediately to review the state court decision might seriously erode federal policy." *Cox Broad.*, 420 U.S. at 482-83; Pet. for Cert. 35-36, No. 13-1305 (U.S. Apr. 28, 2014); U.S. Invitation Br. 19-20. "Forcing a FEHB carrier to defend against a putative state-law class action seeking damages because the carrier performed its contractual commitments to OPM and exercised its subrogation rights would plainly undermine OPM's policy that carriers should exercise their subrogation

rights unimpeded by such parochial state laws." U.S. Invitation Br. 20.

Nevils's makeweight assertion in unsuccessfully opposing Coventry's prior petition that Coventry's contract did not authorize it to seek reimbursement is meritless. As the Missouri Supreme Court expressly held in *Nevils I*, Coventry's contract "direct[ed] [it] to seek reimbursement or subrogation" in these circumstances. Pet. App. 45a. That "interpretation of the contract," the government and Coventry showed, "is correct." U.S. Invitation Br. 18; Cert. Reply 12, No. 13-1305 (U.S. July 16, 2014). Nevils himself, in fact, repeatedly told the state courts the same thing, agreeing that Coventry's contract authorized reimbursement and urging the state courts to decide the federal issues on that basis. *See* Coventry Remand Br. 89-92. And although on remand Nevils changed his tune, urging the court below not to reach the preemption issues, the Missouri Supreme Court was unmoved and pressed forward to decide both the statutory and constitutional questions.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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August 1, 2016

APPENDIX

APPENDIX A

SUPREME COURT OF MISSOURI
en banc

JODIE NEVILS,	)	
	)	
APPELLANT,	)	
	)	
vs.	)	**No. SC93134**
	)	
GROUP HEALTH PLAN, INC., and ACS RECOVERY SERVICES, INC.,	)	
	)	
RESPONDENTS.	)	

APPEAL FROM THE CIRCUIT COURT OF ST. LOUIS COUNTY
Honorable Thea A. Sherry, Judge

Opinion issued May 3, 2016

In *Nevils v. Group Health Plan, Inc.*, 418 S.W.3d 451, 457 (Mo. banc 2014), this Court held that 5 U.S.C. section 8902(m)(1) of the Federal Employee Health Benefits Act (FEHBA) did not preempt Missouri law prohibiting subrogation of personal injury claims. The United States Supreme Court granted certiorari, vacated this Court's decision in *Nevils*, and remanded the case for this Court to determine whether a new regulation promulgated by the Office of Personnel Management (OPM) establishes that FEHBA preempts Missouri's anti-subrogation law. *Group Health Plan Inc., v. Nevils,* 135 S. Ct. 2886 (2015).

The United States Supreme Court has never held that a regulation promulgated by an executive branch administrative agency determines the scope of Congress' exercise of its legislative prerogative to expressly preempt state law. Instead, the Court has held consistently that courts should presume that there is no preemption and that a federal statute preempts state law only if it demonstrates Congress' clear and manifest intent to preempt state law. The text of the FEHBA preemption clause has not changed, and the OPM regulation does not overcome the presumption against preemption and demonstrate Congress' clear and manifest intent to preempt state law. Therefore, this Court holds that the OPM regulation does not establish that FEHBA preempts Missouri law prohibiting the subrogation of personal injury claims.

Background

Jodie Nevils (Appellant) was a federal employee with a health insurance plan governed by FEHBA. FEHBA expressly preempts state law as follows:

> The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 U.S.C. section 8902(m)(1).

Appellant filed suit against Group Health Plan, Inc.,[1] and ACS Recovery Services, Inc., after Coven-

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[1] Group Health Plan, Inc., is now Coventry Health Care of Missouri, Inc., and will hereafter be referred to as "Coventry."

try and ACS enforced a subrogation lien against the proceeds from Appellant's settlement of a personal injury claim. Appellant alleged that the subrogation lien violated Missouri law prohibiting the subrogation of personal injury claims. The trial court entered summary judgment in favor of Coventry and ACS on grounds that FEHBA preempts Missouri anti-subrogation law.

This Court reversed the summary judgment and held that the FEHBA preemption clause did not preempt Missouri anti-subrogation law because the subrogation of a personal injury claim does not clearly "relate to the nature, provision, or extent of coverage or benefits." *Nevils*, 418 S.W.3d at 455. This Court's analysis began with the principle that the "historic police powers of the States" are generally preempted only when the federal statute at issue indicates that preemption is the "clear and manifest purpose of Congress." *Id.* at 454 (quoting *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504 (1992)). "[W]hen two plausible readings of a statute are possible, 'we would nevertheless have a duty to accept the reading that dis-favors preemption.'" *Id.* (quoting *Bates v. Dow Agrosciences, L.L.C.*, 544 U.S. 431, 449 (2005)). The FEHBA preemption clause is ambiguous because it is subject to plausible, alternate interpretations. *Id.* at 454 (citing *Empire Healthchoice Assurance, Inc. v. McVeigh*, 547 U.S. 677, 697 (2006)). Specifically, the FEHBA preemption clause does not address the subrogation or reimbursement rights of insurance providers, *id.* at 455 (citing *Empire*, 547 U.S. at 683), and "there is no indication that Congress delegated to the OPM the authority to make binding interpretations of the scope of the FEHBA preemption clause," *id.* at 457 n.2. In addition to the presumption against preemption, this

Court noted that a "cautious" reading of the FEHBA preemption clause was further warranted because the statute takes the unusual step of providing that the terms of a privately negotiated contract preempt state law. *Id.* at 455. Consequently, this Court held that the plain language of the FEHBA preemption clause does not establish a clear and manifest congressional intent to preempt state anti-subrogation law. *Id.* at 457.

Following this Court's opinion in *Nevils*, the OPM promulgated a formal rule providing that:

> A carrier's rights and responsibilities pertaining to subrogation and reimbursement under any FEHB contract relate to the nature, provision, and extent of coverage or benefits (including payments with respect to benefits) within the meaning of 5 U.S.C. 8902(m)(1). These rights and responsibilities are therefore effective notwithstanding any state or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 C.F.R. § 890.106(h). The United States Supreme Court granted certiorari, vacated this Court's decision in *Nevils*, and remanded the case to this Court to determine whether the foregoing rule establishes that FEHBA preempts Missouri's anti-subrogation law.

Analysis

Coventry argues that the OPM's new rule providing that FEHBA preempts state anti-subrogation law is dispositive and requires this Court to hold that FEBHA preempts Missouri's anti-subrogation law. Coventry asserts that the OPM rule is entitled to

deference pursuant to *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). *Chevron* held that when resolving statutory ambiguities, courts should defer to an executive administrative agency's interpretation of the statute through formally promulgated administrative rules. *Id.* 842-43.[2] "*Chevron* deference" is typically applied "[w]here an agency rule sets forth important rights and duties, where the agency focuses fully and directly on the issue, where the agency uses notice-and-comment procedures to promulgate a rule, [and] where the resulting rule falls within the statutory grant of authority." *Long Island Care at Home, Ltd. v. Coke*, 551 U.S. 158, 173 (2007).

The OPM rule at issue was promulgated formally pursuant to notice and comment rulemaking. The text of the FEHBA preemption clause, however, remains unchanged. To reverse course from the holding in *Nevils*, this Court would have to hold that the OPM's rule is dispositive as to Congress' intent to preempt state law. While *Chevron* has been applied repeatedly to determine the substantive meaning of a statute, the United States Supreme Court has never held expressly that *Chevron* deference applies to resolve ambiguities in a preemption clause. Absent binding precedent requiring such deference, this Court declines to afford dispositive deference to an executive agency's interpretation of a statutory preemption clause.

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[2] The statutory term at issue in *Chevron* was a provision of the Federal Clean Air Act establishing permitting requirements for "new or modified major stationary sources." 467 U.S. at 840. Therefore, the Court's holding that the agency rule regarding what constituted a "source" of air pollution was entitled to deference related only to the substantive meaning of the statute rather than its preemption of conflicting state law.

The Supremacy Clause of the United States Constitution provides that state laws and constitutional provisions are preempted when in conflict with federal laws. *See Johnson v. State*, 366 S.W.3d 11, 26-27 (Mo. banc 2012). "In determining whether a state statute is pre-empted by federal law and therefore invalid under the Supremacy Clause of the Constitution, our sole task is to ascertain the intent of Congress." *California Fed. Sav. & Loan Ass'n v. Guerra*, 479 U.S. 272, 280 (1987). "Accordingly, 'the purpose of Congress is the ultimate touchstone of pre-emption analysis.'" *Cipollone*, 505 U.S. 504 at 516 (1992) (quoting *Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978)); *see also Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996) (Congress' purpose is the "ultimate touchstone" for determining the existence and reach of preemption).

While Congress' intent and purpose are the determinative factors, preemption analysis "starts with the basic assumption that Congress did not intend to displace state law." *Maryland v. Louisiana*, 451 U.S. 725, 746 (1981); *see also Cipollone*, 505 U.S. at 516 (preemption analysis "starts with the assumption that the historic police powers of the States [are] not to be superseded by" federal statute). There are two aspects to the presumption against preemption. *City of Belton v. Smoky Hill Ry. & Historical Soc., Inc.*, 170 S.W.3d 429, 434 (Mo. App. 2005) (quoting *Medtronic, Inc.*, 518 U.S. 470 at 485 (1996)). First, it is presumed that the states' historic police powers are not preempted unless it is the clear intent of Congress to preempt state law. *Id.* Second, a court's analysis of the scope of a statute's preemption is determined by the congressional purpose in enacting the statute. *Id.* When two plausible readings of a statute are possible, "we would nevertheless have a

duty to accept the reading that disfavors preemption." *Bates*, 544 U.S. 431 at 449 (2005).

As this Court noted in *Nevils*, the United States Supreme Court has recognized that the FEHBA preemption clause is subject to plausible, alternate interpretations. 418 S.W.3d at 454-455 (citing *Empire Healthchoice Assurance Inc.*, 547 U.S. 677 at 697 (2006)). The Court also noted that the "choice-of-law prescription is unusual in that it renders superior preemptive contract terms in health insurance plans, not provisions enacted by Congress [ ] and that such an unusual order warrants [a] cautious interpretation." *Id.* The fact that the FEHBA preemption clause is susceptible to alternate interpretations implicates the presumption against preemption and counsels that preemption is warranted only if Congress expressed its clear and manifest intent that the purposes of FEHBA require the preemption of state anti-subrogation laws. Coventry's argument that this Court must give dispositive deference to the new OPM rule is a tacit admission that Congress did not express its clear and manifest intent that the purpose of FEHBA requires preemption of state anti-subrogation law.

Cipollone illustrates the Supreme Court's application of the presumption against preemption when an express preemption clause is at issue. In *Cipollone*, the issue was whether the Federal Cigarette Labeling and Advertising Act preempted state law claims based on failure to warn, breach of express warranty, fraudulent misrepresentation, and conspiracy. The act contained an express preemption clause that "governed entirely" the preemptive scope of the Act. 505 U.S. at 517. The preemption clause provided that "[n]o *statement* relating to smoking

and health shall be required *in the advertising* of properly labeled cigarettes." *Id.* The Supreme Court applied the presumption against preemption to analyze separately whether each of the asserted state law claims was preempted. The Supreme Court stated that "we must construe these provisions in light of the presumption against the pre-emption of state police power regulations. This presumption reinforces the appropriateness of a narrow reading ...." *Id.* at 518. The Supreme Court also emphasized that courts "must fairly but – in light of the strong presumption against pre-emption – narrowly construe the precise language of [the preemption clause] and we must look to each of petitioner's common-law claims to determine whether it is in fact preempted." *Id.* at 523.

While *Cipollone* discussed the general presumption against preemption, *Cipollone* did not address the issue of whether an agency rule is entitled to judicial deference when application of the rule may result in preemption. That issue was addressed in *Smiley v. Citibank (S. Dakota), N.A.*, 517 U.S. 735 (1996). In *Smiley*, a California resident filed a class action lawsuit alleging that late payment fees charged by a South Dakota bank were "unconscionable" and illegal under California law. *Id.* at 738. The bank argued that the lawsuit was preempted by the definition of "interest" in section 85 of the National Bank Act. *Id.* The agency that administered the act promulgated a rule providing that the term "interest" included late fees. *Id.* The plaintiff asserted that if the term "interest" included late fees, then California law, that allegedly barred such fees, would be preempted. *Id.* As such, the plaintiff argued the agency rule was not entitled to deference and the presumption against preemption applied. *Id.*

The Supreme Court rejected the plaintiff's argument that the presumption against preemption applied because:

> This argument confuses the question of the substantive (as opposed to pre-emptive) *meaning* of a statute with the question of *whether* a statute is pre-emptive. We may assume (without deciding) that the latter question must always be decided *de novo* by the courts. That is *not* the question at issue here; there is no doubt that § 85 pre-empts state law.

Id. at 744. The Supreme Court further emphasized the distinction between the substantive meaning of a statute and the preemptive reach of a statute by noting that "[w]hat is at issue here is simply the meaning of a provision that does not (like the provision in *Cipollone*) deal with pre-emption, and hence does not bring into play the considerations petitioner raises." *Id.*

Smiley indicates that *Chevron* deference does not apply to provisions, "like the provision in *Cipollone*," that deal expressly with preemption, while it does apply to "substantive" provisions even if application of the substantive provision will have some preemptive effect. Like the preemption clause in *Cipollone*, the FEHBA preemption clause is an express preemption clause. Following the distinction between "substantive" and "preemptive" statutory provisions noted in *Smiley*, this Court concludes that there is no binding precedent requiring courts to afford dispositive deference to an agency rule defining the scope of an express preemption clause. Accordingly, this Court declines to hold that the OPM rule conclusive-

ly resolves the ambiguity in the FEHBA preemption clause.[3]

Contrary to this conclusion, Coventry argues that the case law establishes that the OPM rule is entitled to dispositive deference. Coventry argues that *City of Arlington, Tex. v. F.C.C.*, 133 S.Ct. 1863 (2013), indicates clearly that the courts must defer to an agency rule interpreting a preemption clause. The issue in *City of Arlington* was whether "an agency's interpretation of a statutory ambiguity that concerns the scope its regulatory authority (that is, its jurisdiction) is subject to deference under" *Chevron*. *Id.* at 1866. The Supreme Court held that the rule was entitled to deference because:

> *Chevron* is rooted in a background presumption of congressional intent: namely, that Congress, when it left ambiguity in a statute administered by an agency, understood that the ambiguity would be resolved, first and foremost, by the agency, and desired the agency (rather than the courts) to possess whatever degree of discretion the ambiguity

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[3] In *Wyeth v. Levine*, 555 U.S. 555, 576 (2009), the Supreme Court "recognized that an agency regulation with the force of law can pre-empt conflicting state requirements." The fact that an agency regulation can have preemptive effect does not mean that courts must defer to an agency rule purporting to define the preemptive scope of a statute administered by the agency. To the contrary, "[i]n such cases, the Court has performed its own conflict determination, relying on the substance of state and federal law and not on agency proclamations of preemption." *Id.* Although *Wyeth* did not directly address the issue of *Chevron* deference, *Wyeth* is consistent with *Cipollone* and *Smiley* insofar as each case indicates that the courts are not required to afford dispositive deference to an agency rule regarding preemption.

> allows. *Chevron* thus provides a stable background rule against which Congress can legislate: Statutory ambiguities will be resolved, within the bounds of reasonable interpretation, not by the courts but by the administering agency.

As Coventry asserts, the Supreme Court's holding and rationale in *City of Arlington* is a strong reaffirmation of *Chevron*. However, *City of Arlington* was not a Supremacy Clause case. Instead, as the Supreme Court made a clear, *City of Arlington* was about the reach of the FCC's regulatory authority. Therefore, *City of Arlington* is, at its core, a Commerce Clause case with the attendant presumption that "legislative Acts adjusting the burdens and benefits of economic life come to the Court with a presumption of constitutionality ...." *Hodel v. Indiana*, 452 U.S. 314, 323 (1981) (quoting *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 15 (1976)). *City of Arlington* does not require this Court to hold that the OPM rule is entitled to *Chevron* deference.

Coventry also asserts that *Cuomo v. Clearing House Association, L.L.C.*, 557 U.S. 519, 531 (2009), holds that Chevron deference applies to express preemption clauses. In *Cuomo*, the issue was whether an agency regulation purporting to pre-empt state law enforcement can be upheld as a "reasonable interpretation of the National Bank Act." *Id.* at 523-524. The Supreme Court noted that *Chevron* deference generally applies to agency regulations. *Id.* at 525. However, as Coventry notes, the Supreme Court did not actually apply *Chevron* deference because the agency's regulation did not comport with the statute. *Id.* at 531. *Cuomo* does not hold that an

agency regulation interpreting an express preemption clause is entitled to *Chevron* deference.

Coventry also cites *Helfrich v. Blue Cross & Blue Shield Ass'n*, 804 F.3d 1090 (10th Cir. 2015). In *Helfrich*, the Tenth Circuit held that the same OPM regulation at issue in this case supports a finding that FEHBA preempts state anti-subrogation law. *Id.* at 1110. *Helfrich* reasoned that the presumption against preemption did not apply because the federalism issues that underlie the presumption have "little purchase" when addressing the FEHBA preemption clause because of the federal interest in establishing a uniform set of health insurance benefits for federal employees. *Id.* at 1105. There is no doubt that there is strong federal interest in regulating the provision of health insurance benefits for federal employees. However, it is also true that Missouri has an interest in the uniform enforcement of its anti-subrogation law for all of its citizens. More importantly, even with the federal interest in providing uniform insurance benefits for federal employees, the presumption against preemption still applies because, as indicated in *Empire*, the FEHBA preemption clause is ambiguous and warrants a "cautious interpretation" due to the fact of its "unusual" provision permitting contract terms to preempt state law. 547 U.S. at 697. Respectfully, this Court is not bound by and declines to follow *Helfrich*.

Finally, Coventry notes that in *Kobold v. Aetna Life Ins. Co.*, (Ariz. Ct. App. March 31, 2016), the Court held that the OPM rule at issue in this case is entitled *Chevron* deference. Respectfully, for the reasons noted above, this Court is not bound by and declines to follow *Kobold*.

Conclusion

The OPM rule does not alter the fact that the FEHBA preemption clause does not express Congress' clear and manifest intent to preempt Missouri's anti-subrogation law. The circuit court's judgment in favor of Coventry is reversed, and the case is remanded.

Richard B. Teitelman, Judge

Fischer, Stith, Draper and Russell, JJ., concur; Wilson, J., concurs in result in separate opinion filed; Breckenridge, C.J., Fischer, Stith, Draper and Russell, JJ., concur in opinion of Wilson, J.

SUPREME COURT OF MISSOURI
en banc

JODIE NEVILS,	)	
	)	
Appellant,	)	
	)	
v.	)	No. SC93134
	)	
GROUP HEALTH PLAN, INC., and ACS RECOVERY SERVICES, INC.,	)	
	)	
Respondents.	)	

OPINION CONCURRING IN RESULT

As stated in my separate opinion in *Nevils v. Group Health Plan, Inc.*, 418 S.W.3d 451, 457 (Mo. banc 2014), even if the majority opinion is incorrect and the repayment terms in GHP's contract do fall within the reach of the preemption provision in 5 U.S.C. § 8902(m)(1), that statute's attempt to give preemptive effect to the provisions of a contract between the federal government and a private party is not a valid application of the Supremacy Clause in article VI of the United States Constitution and, therefore, does not displace Missouri law here. Accordingly, for all of the reasons stated in that separate opinion, I concur in the result reached in the majority opinion in this case.

_____

Paul C. Wilson, Judge

APPENDIX B

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

JODIE NEVILS,	)	
	)	
Plaintiff,	)	
	)	
v.	)	No. 4:11 CV 588 DDN
	)	
GROUP HEALTH PLAN, INC.,	)	
	)	
	)	
Defendant.	)	

MEMORANDUM AND ORDER OF REMAND

This action is before the court on the motion of plaintiff Jodie Nevils to remand. (Doc. 21.) The parties have consented to the exercise of plenary authority by the undersigned United States Magistrate Judge pursuant to 28 U.S.C. § 636(c). Oral arguments were heard on May 19, 2011.

I. BACKGROUND

On February 9, 2011, plaintiff Jodie Nevils commenced this action on behalf of himself and other similarly situated persons in the Circuit Court of St. Louis County. (Doc. 4.) Defendant Group Health Plan, Inc. removed the case to this court pursuant to federal officer removal jurisdiction, 28 U.S.C. § 1442(a)(1), and pursuant to 28 U.S.C. § 1441(a), based on federal question jurisdiction, 28 U.S.C. § 1331.

According to the complaint, defendant is a private corporate entity that contracts to provide health insurance to individual persons. (Doc. 4 at ¶ 2.) Defendant also contracts with the United States government, through the Office of Personnel Management (OPM), as a "carrier" to administer healthcare benefits in accordance with the Federal Employee Health Benefits Act (FEHBA).[1] (Id. at ¶ 3.)

On November 2, 2006, plaintiff was injured in a motor vehicle accident, and received treatment from numerous healthcare providers. (Id. at ¶¶ 18-19.) Plaintiff brought a personal injury claim against the other driver for his injuries, and the parties reached a settlement to compensate plaintiff for his injuries, medical treatment, pain, and suffering. (Id. at ¶¶ 20-21.) The settlement was paid through the other driver's automobile insurance policy. (Id. at ¶ 21.)

Plaintiff also received medical insurance coverage through a federal health plan, which was governed by FEHBA and for which defendant acted as "carrier" to provide healthcare benefits. (Id. at ¶¶ 22-23.) After paying plaintiff's medical bills arising from the automobile accident, defendant asserted a lien for $6,592.24 for healthcare benefits and services provided to plaintiff related to the automobile accident. (Doc. 4 at ¶¶ 24-25.) On January 29, 2010, plaintiff paid $6,592.24 to defendant through defendant's agent, ACS Recovery. (Id. at ¶ 30.) Thereafter, defendant converted the funds from plaintiff's personal injury settlement. (Id. at ¶ 31.)

Plaintiff asserts four claims on behalf of himself and other persons similarly situated. In Count I,

---

[1] The Federal Employees Health Benefits Act of 1959, 5 U.S.C. § 8901, et seq.

plaintiff alleges defendant violated the Missouri Merchandising Practices Act by performing unfair practices and breaching its duty of good faith. (Id. at ¶¶ 40-47.) In Count II, plaintiff alleges defendant was unjustly enriched by unlawfully receiving and retaining the benefits of proceeds to which it was not entitled. (Id. at ¶¶ 48-52.) In Count III, plaintiff asserts a conversion claim for the money paid to defendant. (Id. at ¶¶ 53-57.) In Count IV, plaintiff seeks to enjoin defendant from performing the alleged predatory and unfair practices on consumers such as plaintiff. (Doc. 4 at ¶¶ 58-62.)

II. MOTION TO REMAND

Plaintiff moves to remand the action to state court for lack of subject matter jurisdiction. Plaintiff argues that removal was not permitted under 28 U.S.C. § 1442(a)(1), because defendant was not acting under the direction of a federal officer when it sought subrogation from plaintiff, and because defendant does not have a colorable federal defense. Plaintiff further argues removal is improper under 28 U.S.C. § 1441(a), because FEHBA's preemption provision does not confer subject matter jurisdiction upon the court, and because federal interests in uniformity differ from those interests secured by FEHBA's preemption provision. (Doc. 21.)

Defendant responds that removal is proper under 28 U.S.C. § 1442(a)(1), because it was acting under the direction of OPM, as set forth in the contract between defendant and OPM (OPM-GHP Contract), when it sought subrogation from plaintiff. Defendant also argues that it has a colorable federal defense—that plaintiff's claims are expressly preempted by the terms of the OPM-GHP Contract. Defendant further argues that removal is proper under

28 U.S.C. § 1441(a), because plaintiff's claims implicate federal government interests, and plaintiff's claims present a conflict between federal interests and state law. (Doc. 25.)

Plaintiff replies that subject matter jurisdiction does not exist, because the subrogation provision of the OPM-GHP Contract does not relate to "benefits," and thus cannot preempt contrary state law. Plaintiff also replies that the subrogation provision does not further a federal interest or policy in uniformity. (Doc. 28.)

III. DISCUSSION

A. FEHBA

FEHBA "establishes a comprehensive program of health insurance for federal employees," and authorizes the OPM "to contract with private carriers to offer federal employees an array of health-care plans." Empire HealthChoice Assur., Inc. v. McVeigh, 547 U.S. 677, 682 (2006). See 5 U.S.C. § 8902(a). Thus, "FEHBA assigns to OPM responsibility for negotiating and regulating health-benefit plans for federal employees." Empire, 547 U.S. at 683. FEHBA requires that contracts between OPM and carriers "contain a detailed statement of benefits offered" and allows OPM to "prescribe reasonable minimum standards for health benefits plans ... and for carriers." 5 U.S.C. §§ 8902(d), (e). OPM also has the authority to withdraw approval of a carrier for failing to comply with certain minimum standards. 5 C.F.R. § 890.204.

FEHBA contains one preemption provision, under which "[t]he terms of any contract ... which relate to the nature, provision, or extent of coverage or benefits (including payment with respect to bene-

fits) ... supercede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." 5 U.S.C. § 8902(m)(1).

FEHBA vests in federal district courts "original jurisdiction, concurrent with the United States Court of Federal Claims, of a civil action or claim against the United States founded on this chapter." 5 U.S.C. § 8912; see Empire, 547 U.S. at 686 (noting that FEHBA contains "but one provision addressed to federal-court jurisdiction").

B. OPM-GHP Contract

The relevant provision of the OPM-GHP Contract states:

> Part II – Benefits
>
> Section 2.5: Subrogation
>
> (a) The Carrier shall subrogate FEHB claims in the same manner in which it subrogates claims for non-FEHB members, according to the following rules:
>
> ***
>
> (2) The Carrier shall subrogate FEHB claims if it is doing business in a State in which subrogation is prohibited, but in which the Carrier subrogates for at least one plan covered under the Employee Retirement Income Security Act of 1974 (ERISA);

(Doc. 1-3 at 23, Doc 1-4 at 24). The parties agree that this provision is applicable, because defendant subrogates for at least one self-insured plan covered under ERISA (Doc. 1-10, Dickerson Dec. at ¶ 3), and

because under Missouri law, an insurer has no right of subrogation against its own insured. Benton House, LLC v. Cook & Younts Ins., Inc., 249 S.W.3d 878, 882 (Mo. Ct. App. 2008) ("No right of subrogation can arise in favor of an insurer against its own insured, since, by definition, subrogation arises only with respect to rights of the insured against third persons to whom the insurer owes no duty.").

C. 28 U.S.C. § 1442(a)(1)

Title 28 U.S.C. § 1442(a)(1) "grants independent jurisdictional grounds over cases involving federal officers where a district court otherwise would not have jurisdiction." Johnson v. Showers, 747 F.2d 1228, 1229 (8th Cir. 1984).[2] Removal is proper under § 1442(a)(1) when "(1) a defendant has acted under the direction of a federal officer, (2) there was a causal connection between its actions and the official authority, (3) the defendant has a colorable federal defense to the plaintiff's claims, and (4) the defendant is a 'person' within the meaning of the statute." Dahl v. R.J. Reynolds Tobacco Co., 478 F.3d 965, 967

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[2] This section, entitled "Federal officers or agencies sued or prosecuted," states:

> (a) A civil action ... commenced in a State court against any of the following may be removed by them to the district court of the United States for the district and division embracing the place wherein it is pending:
>
> > (1) The United States or any agency thereof or any officer (or any person acting under that officer) of the United States or of any agency thereof, sued in an official or individual capacity for any act under color of such office or on account of any right, title or authority claimed under any Act of Congress for the apprehension or punishment of criminals or the collection of the revenue.

28 U.S.C. § 1442(a)(1).

n.2 (8th Cir. 2007). While the statute as a whole must be liberally construed, Watson v. Philip Morris Cos., Inc., 551 U.S. 142, 147 (2007); Willingham v. Morgan, 395 U.S. 402, 407 (1969), "it must nevertheless be interpreted with the highest regard for the right of the states to make and enforce their own laws in the field belonging to them under the Constitution." Joseph v. Fluor Corp., 513 F. Supp. 2d 664, 673 (E.D. La. 2007). "If the right to remove [under § 1442(a)(1)] is doubtful, the case should be remanded." Dunevant v. Healthcare USA of Missouri, LLC, No. 4:08CV702 FRB, 2008 WL 4066384, at *2 (E.D. Mo. Aug. 27, 2008). The defendant bears the burden of establishing the existence of jurisdiction under § 1442(a)(1). Van Horn v. Arkansas Blue Cross & Blue Shield, 629 F. Supp. 2d 905, 913 (E.D. Ark. 2007).

1. "Acted Under The Direction Of A Federal Officer"

To satisfy the "acted under" requirement, a private person's actions "must involve an effort to assist, or to help carry out, the duties or tasks of the federal superior." Watson, 551 U.S. at 151-52 (emphasis omitted). Further, the federal entity must have exercised "direct and detailed control" over the private party. Culver v. Asbestos Defendants (BP), No. C 10-03484 SI, 2010 WL 5094698, at *5 (N.D. Cal. Dec. 8, 2010). A relationship satisfying the statute's "acting under" requirement will "typically involve[] subjection, guidance, or control." Watson, 551 U.S. at 151-52 (internal quotation omitted). The Supreme Court has cautioned that although "the words 'acting under' are broad, ... broad language is not limitless" and a liberal statutory construction

"can find limits in a text's language, context, history, and purposes." Id. at 147.

Defendant asserts that it was directed to seek subrogation from plaintiff by OPM in the OPM-GHP Contract. See Doc. 1-3 at 23, Doc 1-4 at 24-25. Plaintiff does not dispute that the terms of the OPM-GHP Contract directed defendant to seek subrogation. Compare Doc. 1-3 at 23, Doc. 1-4 at 24 ("The Carrier shall subrogate ...") with Van Horn, 629 F. Supp. 2d at 914 ("[T]he Carrier, in its discretion ..."). Rather, plaintiff challenges whether defendant's compliance with a negotiated contract with OPM is sufficient to satisfy the "acted under" requirement.

In Orthopedic Specialists of New Jersey PA v. Horizon Blue Cross/Blue Shield of New Jersey, 518 F. Supp. 2d 128 (D.N.J. 2007), the court noted that a contract between a carrier and OPM does not necessarily satisfy the "acted under" requirement. Orthopedic Specialists, 518 F. Supp. 2d at 135 n.4. The court explained that FEHBA carriers "freely enter[] into the market, in which ... carriers 'compete vigorously' with other providers for customers within the pool of federal employees." Id. (quoting Houston Cmty. Hosp. v. Blue Cross & Blue Shield of Texas, Inc., 481 F.3d 265, 272 (5th Cir. 2007)). As a result, "OPM does not unilaterally determine what benefits are included in the ... service plan," but rather, "OPM and [the carrier] together *contract* to determine what benefits will be included." Orthopedic Specialists, 518 F. Supp. 2d at 135 n.4 (emphasis in original) (quotations omitted). Therefore, "a provider's duty to abide by contract terms does not necessarily amount to 'control' over the Plan provider." Id.; see also Arnold v. Blue Cross & Blue Shield of

Texas, Inc., 973 F. Supp. 726, 740-41 (S.D. Tex. 1997) ("[The carrier] has offered no evidence to show that its contract negotiations with OPM involve anything other than arms-length bilateral give-and-take."), overruled on other grounds in Winters v. Diamond Shamrock Chem. Co., 149 F.3d 387 (5th Cir. 1998).

The Second Circuit gave a similar account of the FEHBA contract creation process in Empire HealthChoice Assurance, Inc. v. McVeigh, 396 F.3d 136 (2d Cir. 2005), aff'd 547 U.S. 677 (2006). There, the Second Circuit characterized "FEHBA-authorized contracts" as "privately-negotiated contract[s]." Id. at 144. The court explained that "[u]nder FEHBA, the government does not impose contract terms as it would impose a law. Rather, the OPM negotiates the contract terms privately with insurance providers, who are under no obligation to enter into contracts in the first place." Id. (internal citation omitted).

Thus, the relationship between OPM and defendant is not one of "subjection, guidance, or control." Watson, 551 U.S. at 151-52. As a result, defendant's compliance with the terms of the OPM-GHP Contract does not amount to "acting under the direction of a federal officer."

Defendant also contends it was obligated to seek subrogation from plaintiff by 48 C.F.R. § 1609.7001(b)(3), which states:

> (b) [T]he carrier must perform the contract in accordance with prudent business practices. A carrier's sustained poor business practice in the management or administration of a health benefits plan is cause for OPM's withdrawal of approval of the health benefits car-

> rier and termination of the carrier's contract. Prudent business practices include, but are not limited to, the following:
>
> ***
>
> (3) Compliance with the terms of the FEHB Contract, regulations and statutes.

48 C.F.R. § 1609.7001(b)(3). The Supreme Court, however, has definitively stated that compliance with regulations alone does not establish the requisite control, "even if the private firm's activities are highly supervised or monitored." Watson, 551 U.S. at 153. Moreover, 48 C.F.R. § 1609.7001(b)(3) does not require inclusion of the subrogation provision in all contracts between OPM and carriers; it generally requires compliance with contract terms that are agreed upon by OPM and carriers through contract negotiations. See Orthopedic Specialists, 518 F. Supp. 2d at 135 n.4 (noting that "[d]ifferences among plans results from the fact that OPM enters separate negotiations with each carrier") (quotation omitted); Arnold, 973 F. Supp. at 941 (explaining that "OPM does not merely produce a list of benefits for which it requires coverage"); cf. Group Health Inc. v. Blue Cross Ass'n, 587 F. Supp. 887, 891 (S.D.N.Y. 1984) (finding § 1442(a)(1) removal proper because "Medicare fiscal intermediaries act as agents at the sole direction of the Secretary of HHS") (internal quotations omitted).

Therefore, defendant has not satisfied its burden of establishing that it was subject to OPM's direct and detailed control through the OPM-GHP Contract. In the absence of evidence that the subrogation provision was created and included at the direction of OPM, or evidence of a special relationship be-

tween defendant and OPM, defendant's compliance with the OPM-GHP Contract does not satisfy the "acted under" requirement. See Watson, 551 U.S. at 153 (compliance with federal laws, rules, or regulations is not "acting under the direction of a federal official," and "[a] contrary determination would expand the scope of [§ 1442(a)(1)] considerably, potentially bringing within its scope state-court actions filed against private firms in many highly regulated industries").

Because defendant has not satisfied the first requirement for removal under § 1442(a)(1), the court will not address the remaining requirements. See In re Methyl Tertiary Butyl Ether ("MTBE") Prods. Liab. Litig., 488 F.3d 112, 132 (2d Cir. 2007).

D. 28 U.S.C. § 1331

Title 28 U.S.C. § 1331 states that federal district courts "shall have original jurisdiction over all civil actions arising under the Constitution, laws, or treaties of the United States." 28 U.S.C. § 1331. "A case 'aris[es] under' federal law within the meaning of § 1331 ... if a well-pleaded complaint establishes either that federal law creates the cause of action or that the plaintiff's right to relief necessarily depends on resolution of a substantial question of federal law." Empire, 547 U.S. at 689-90 (internal quotation omitted). Included in the "laws" of § 1331 is federal common law. Nat'l Farmers Union Ins. Cos. v. Crow Tribe, 471 U.S. 845, 850 (1985). "Absent congressional authorization, ... courts may only create federal common law where the operation of state law would (1) 'significant[ly] conflict' with (2) 'uniquely federal interest[s].'" Empire, 396 F.3d at 140-41 (quoting Boyle v. United Techs. Corp., 487 U.S. 500, 507-08 (1988)). This category of cases is "extremely

small." Morgan Cnty. War Mem'l Hosp. v. Baker, 314 Fed. App'x 529, 533 (4th Cir. 2008) (per curiam); see also O'Melveny & Myers v. FDIC, 512 U.S. 79, 87 (1994) (noting that this category of cases is "few and restricted").

Defendant argues that the court has jurisdiction under § 1331 because plaintiff's claims, brought under Missouri law, undermine the federal government's interests in enforcing its contracts, protecting its contractors from liability for complying with its contracts, and the uniform treatment of the carriers with which it contracts.

Defendant's assertion is based on the premise that Missouri law conflicts with the operation of the OPM-GHP Contract. Although Missouri law prohibits subrogation by an insurer against an insured, Benton House, 249 S.W.3d at 882, the Missouri Court of Appeals has stated that "Missouri state law prohibiting subrogation is preempted by the FEHBA." Buatte v. Gencare Health Sys., Inc., 939 S.W.2d 440, 442 (Mo. Ct. App. 1996). Although Missouri courts may wish to revisit this holding in light of subsequent developments of the law, see, e.g., Blue Cross Blue Shield of Illinois v. Cruz, 495 F.3d 510 (7th Cir. 2007) (distinguishing between "benefits" and "financial incident[s]"), Missouri law presently does not appear to conflict with the operation of the OPM-GHP Contract. Blue Cross Blue Shield Health Care Plan of Georgia, Inc. v. Gunter, 541 F.3d 1320, 1322-23 (11th Cir. 2008) (finding no significant conflict between state's complete compensation rule and contrary FEHBA contract terms because the state supreme court "expressly held that the complete compensation rule is not applied when FEHBA is applicable"). "[T]he possibility that at a later stage

in the proceedings, a significant conflict might arise between [Missouri] state law and the federal interests underlying FEHBA" is "insufficient to confer federal jurisdiction." Empire, 396 F.3d at 142.

Therefore, defendant has not established that the court has jurisdiction over the action under § 1331. Because the court lacks subject matter jurisdiction, the case must be remanded to the Circuit Court of St. Louis County for further proceedings.

IV. CONCLUSION

For the reasons set forth above,

IT IS HEREBY ORDERED that the motion of plaintiff Jodie Nevils to remand (Doc. 21) is hereby sustained. The case is remanded to the Circuit Court of St. Louis County for further proceedings.

IT IS FURTHER ORDERED that the motion of defendant Group Health Plan, Inc. for judgment on the pleadings (Doc. 8) is deferred to the Missouri circuit court.

s/ David D. Noce
UNITED STATES MAGISTRATE JUDGE

Signed on June 15, 2011.

APPENDIX C

IN THE CIRCUIT COURT OF THE COUNTY OF ST. LOUIS STATE OF MISSOURI

JODIE NEVILS,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	Cause No.
	)	11SL-CC00535
GROUP HEALTH PLAN, INC.	)	
and ACS RECOVERY SER-	)	Division 5
VICES, INC.,	)	
	)	
Defendants.	)	

ORDER AND JUDGMENT

This matter is before the Court on defendants Group Health Plan, Inc.'s [hereinafter "GHP" and ACS Recovery Services, Inc.'s [hereinafter "ACS"] motions for summary judgment. The motions were called, heard and taken under submission on January 27, 2012. The parties appeared by their respective counsel. Having heard the arguments of counsel, having read the statements of facts, memoranda of law and exhibits submitted, and being now duly advised, the Court enters the following Order and Judgment:

The plaintiff, Jodie Nevils, was insured through a federal employee health plan governed by the Federal Employees Health Benefits Act [hereinafter "FEHBA"] and administered by GHP pursuant to a contract with the federal Office of Personnel Man-

agement [hereinafter "OPM"]. Section 2.5 of GHP's FEHBA contract with the OPM, entitled "subrogation" and located in the "Benefits" section of the contract, provided in pertinent part as follows:

> (a) The Carrier [GHP] shall subrogate FEHB claims in the same manner in which it subrogates claims for non-FEHB members, according to the following rules:
>
> ***
>
> (2) The Carrier shall subrogate FEHB claims if it is doing business in a State in which subrogation is prohibited, but in which the Carrier subrogates for at least one plan covered under the Employee Retirement Income Security Act of 1974 (ERISA).

GHP subrogates in Missouri for at least one ERISA plan. Under the terms of the contract, members who enrolled in or accepted services under the contract were obligated to all its terms, conditions and provisions.

The plaintiff was injured in an auto accident, and his medical bills were paid by the federal health plan. The plaintiff sued the other driver and reached a settlement, against which GHP, through its agent ACS, asserted a lien for $6,592.24. The plaintiff paid the lien and then filed this suit against the defendants.

The plaintiff's First Amended Petition claims the defendants' assertion of a lien violated Missouri's anti-subrogation law. The causes of action include: Count I - violation of the Missouri Merchandising Practices Act; Count II - unjust enrichment; Count III - conversion; and Count IV - injunctive relief. The defendants contend that Missouri's anti-subrogation

law is preempted by FEHBA, which allows for subrogation and reimbursement of payments made for injuries to health plan members caused by third-party tortfeasors.

Summary judgment is designed to permit the trial court to enter judgment, without delay, where the moving party has demonstrated, on the basis of facts as to which there is no genuine dispute, a right to judgment as a matter of law. *ITT Commercial Finance Corp. v. Mid-America Marine Supply Corp.*, 854 S.W.2d 371, 381 (Mo. banc 1993).

Missouri courts have declared that it is against the public policy of the state to allow a health insurer a right, by assignment or subrogation, to reimbursement of medical bills it has paid on behalf of its insured for injuries caused by a third-party tortfeasor. *Schweiss v. Sisters of Mercy, St. Louis, Inc.*, 950 S.W.2d 537, 538 (Mo. App., E.D. 1997). However, as noted above, the OPM/GHP contract contained a provision that required GHP to subrogate on FEHBA claims in states where GHP subrogated for at least one ERISA plan.

FEHBA has a preemption clause at 5 U.S.C.A. § 8902(m)(1), which provides as follows:

> The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

Missouri addressed the question of whether § 8902(m)(1)[1] preempts Missouri's anti-subrogation law in *Buatte v. Gencare Health Sys., Inc.*, 939 S.W.2d 440 (Mo. App., E.D. 1996). In that case, the plaintiffs had settled a personal injury case but refused Gencare's request for reimbursement of medical benefits paid by the FEHBA plan it administered. The Court of Appeals held:

> We likewise find that Missouri state law prohibiting subrogation is preempted by the FEHBA. The FEHBA requires preemption of state law if it would differ the "nature or extent of coverage or benefits" offered under the FEHBA authorized plan. In the present case, prohibiting Gencare from seeking reimbursement from its insured would clearly differ the extent of coverage or benefits.

Id. at 442.

The court has thoroughly considered the plaintiff's claims that *Buatte* is no longer good law in light of more recent court decisions. However, no case has overruled *Buatte,* and it is still the law in Missouri. "Where the same or an analogous issue was decided in an earlier case, such case stands as authoritative precedent unless and until it is overruled." *M & H Enterprises v. Tri-State Delta Chemicals, Inc.*, 984 S.W.2d 175, 178 n. 3 (Mo. App., S.D. 1998). Any reconsideration of the *Buatte* holding in light of recent cases would be appropriate in the Court of Appeals. Since Missouri law holds that FEHBA

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[1] An earlier version of § 8902(m)(1) was in effect at the time of the *Buatte* decision. That version included the words "to the extent that such law or regulation is inconsistent with such contractual provisions" at the end of the sentence.

preempts Missouri's anti-subrogation law, the defendants' motions for summary judgment on all counts are granted.

Accordingly, defendant Group Health Plan, Inc.'s Motion for Summary Judgment is GRANTED. Judgment on all counts of plaintiff's First Amended Petition is entered in favor of defendant, Group Health Plan, Inc. and against plaintiff, Jodie Nevils.

Defendant ACS Recovery Services, Inc.'s Motion for Summary Judgment is GRANTED. Judgment on all counts of plaintiff's First Amended Petition is entered in favor of defendant ACS Recovery Services, Inc. and against plaintiff, Jodie Nevils.

SO ORDERED:

May 21, 2012
Date

s/
Thea A. Sherry, Judge

* * *

APPENDIX D

In the Missouri Court of Appeals
Eastern District

DIVISION ONE

JODIE NEVILS,	)	ED98538
	)	
Plaintiff/Appellant,	)	Appeal from the
	)	Circuit Court of
v.	)	St. Louis County
	)	
GROUP HEALTH PLAN, INC. and ACS RECOVERY SERVICES, INC.,	)	Honorable Thea A. Sherry
	)	
	)	
Defendants/Respondents.	)	Filed:
	)	December 26, 2012

Introduction

Jodie Nevils (Appellant) appeals from the trial court's summary judgment in favor of Group Health Plan, Inc. (GHP) and ACS Recovery Services, Inc. (ACS) (collectively Respondents) on Appellant's petition alleging violation of the Missouri Merchandising Practices Act (MMPA); unjust enrichment; conversion, and seeking injunctive relief. We affirm.

Factual and Procedural Background

On November 2, 2006, Appellant, a federal employee, was injured in an automobile accident. As a federal employee, Appellant had medical coverage through a federal employee health benefit plan carried by GHP. GHP paid Appellant's medical bills resulting from the treatment of his injuries. Appellant

subsequently sued the third party tortfeasor responsible for the accident, and recovered a settlement. GHP, through its agent ACS, asserted a lien against Appellant's settlement in the amount of $6,592.24, seeking reimbursement or subrogation for its payment of Appellant's medical bills resulting from the accident. Appellant remitted the $6,592.24 to GHP in satisfaction of the asserted lien, and then on February 9, 2011, filed a class action petition for damages on behalf of himself and others similarly situated against GHP alleging violation of the MMPA; unjust enrichment; conversion; and seeking injunctive relief, all based on the underlying premise that Missouri law does not permit the subrogation of tort claims. GHP filed a Notice of Removal to federal court, asserting that federal question jurisdiction existed under 28 U.S.C. Section 1331, because the federal government's interest in enforcing its contracts conflicted with Missouri anti-subrogation law.

Appellant moved to remand to state court. The United States District Court for the Eastern District of Missouri remanded the case to the trial court, finding no need for federal jurisdiction because Missouri law "presently does not appear to conflict with the operation of the OPM-GHP Contract." OPM is the federal government's Office of Personnel Management, which contracted with GHP for GHP to act as the health insurance carrier for federal employees' health care benefits. The federal court based its decision on this Court's statement that Missouri's anti-subrogation rule is preempted by the Federal Employee Health Benefits Act (FEHBA), 5 U.S.C. Sections 8901-8914, in Buatte v. Gencare Health Sys., Inc., 939 S.W.2d 440, 442 (Mo.App. E.D. 1996). See Nevils v. Group Health Plan, Inc., 2011 WL 8144366 at *6 (E.D. Mo., June 15, 2011) ("Missouri state law

prohibiting subrogation is preempted by the FEHBA.").

On remand, ACS intervened in the action, and on October 31, 2011, Appellant amended his petition to include ACS as a defendant. Respondents filed motions for summary judgment based on Buatte and FEHBA's preemption clause, 5 U.S.C. Section 8902(m)(1). The trial court granted the motions for the reasons stated by Respondents. This appeal follows.

Point on Appeal

In his point on appeal, Appellant contends the trial court erred in granting Respondents summary judgment because FEHBA does not expressly preempt Missouri's anti-subrogation rule, in that asserted rights to subrogation and reimbursement of medical bill payments do not relate to the "nature, provision or extent of coverage or benefits."

Standard of Review

This Court's standard of review for an appeal of the trial court's entry of summary judgment is *de novo*. ITT Commercial Fin. Corp. v. Mid-America Marine Supply Corp., 854 S.W.2d 371, 376 (Mo.banc 1993). We review the record in the light most favorable to the party against whom judgment was entered. Id. Any facts set forth by affidavit or otherwise in support of a party's motion are taken as true unless contradicted by the non-moving party's response to the summary judgment motion. Id. All reasonable inferences are drawn in favor of the nonmovant. Id. After reviewing the evidence in this manner, this Court will only affirm the trial court's entry of summary judgment if the moving party establishes that there is no genuine issue as to the ma-

terial facts and the movant is entitled to judgment as a matter of law. Goerlitz v. City of Maryville, 333 S.W.3d 450, 452 (Mo.banc 2011).

Discussion

Under the Supremacy Clause, state laws and constitutional provisions are preempted and have no effect to the extent they conflict with federal laws. See State ex rel. Proctor v. Messina, 320 S.W.3d 145, 148 (Mo. banc 2010); Johnson v. State, 366 S.W.3d 11, 26-27 (Mo.banc 2012).

Missouri law, as a matter of public policy, does not allow an insurer to acquire part of the insured's rights against a tortfeasor through the payment of medical expense, either by assignment or subrogation. Buatte, 939 S.W.2d at 441-42; Waye v. Bankers Multiple Line Ins. Co., 796 S.W.2d 660, 661 (Mo.App. W.D. 1990). Insurance policies which attempt to do so are, therefore, invalid under state law. Buatte, 939 S.W.2d at 442. Section 2.5 of OPM's FEHBA contract with GHP, titled "Subrogation" and located under "Benefits," purports to allow GHP to acquire part of an insured's rights against a tortfeasor through the payment of medical expense by subrogation as follows:

> (a) The Carrier [GHP] shall subrogate FEHB[A] claims in the same manner in which it subrogates claims for non-FEHB[A] members, according to the following rules:
>
> ...
>
> (2) The Carrier shall subrogate FEHB[A] claims if it is doing business in a State in which subrogation is prohibited, but in which the Carrier subrogates for at least one plan

> covered under the Employee Retirement Income Security Act of 1974 (ERISA).

Under Section 2.5(a)(2), this subrogation clause is applicable in the instant case because (1) Missouri law prohibits an insurer from subrogation against its own insured, see Benton House, LLC v. Cook & Younts Ins., Inc., 249 S.W.3d 878, 882 (Mo.App. 2008) ("No right of subrogation can arise in favor of an insurer against its own insured, since, by definition, subrogation arises only with respect to rights of the insured against third persons to whom the insurer owes no duty."); and (2) GHP subrogates in Missouri for at least one ERISA plan.

Normally, such a subrogation provision as Section 2.5(a) would be deemed invalid by Missouri courts. However, FEHBA preempts any state law prohibiting subrogation in the manner effected by Respondents against Appellant's settlement award, via the following language:

> The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payment with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 U.S.C. Section 8902(m)(1). The contract between OPM and GHP is a "contract under this chapter." Under the terms of the contract, members who enroll in or accept services under the contract, such as Appellant, are obligated to all of its terms, conditions and provisions. Therefore, the preemption clause pertains to this case, both statutorily under Section

8902(m)(1) and contractually pursuant to the insurance policy.

Appellant maintains the preemption clause, although pertinent to this case, should not be applied here because asserted rights to subrogation and reimbursement of medical bill payments do not relate to the "nature, provision or extent of coverage or benefits." However, this Court has already determined this issue to the contrary:

> Although no Missouri cases have addressed the FEHBA's preemption of inconsistent state law, the FEHBA has been found to preempt state law in other jurisdictions. Those courts have enforced subrogation and reimbursement clauses of health plans where state law would not have permitted the same. In NALC Health Benefit Plan v. Lunsford, 879 F.Supp. 760 (E.D.Mich.1995), a U.S. District Court in Michigan upheld a requirement that enrollees reimburse the plan from any third party proceeds they collected, even though under Michigan law such reimbursement would not have been permissible.
>
> Similarly, in Medcenters Health Care v. Ochs, 854 F.Supp. 589 (D.Minn.1993), the insurer sought reimbursement from the insured after the insured had settled with a third party tortfeasor. The Minnesota District Court found that the provisions of the plan permitting such recovery preempted Minnesota state law which would not permit reimbursement unless the insured had received a full recovery.

> We likewise find that Missouri state law prohibiting subrogation is preempted by the FEHBA. The FEHBA requires preemption of state law if it would differ the 'nature or extent of coverage or benefits' offered under the FEHBA authorized plan. In the present case, prohibiting Gencare from seeking reimbursement from its insured would clearly differ the extent of coverage or benefits.

Buatte, 939 S.W.2d at 442. See also Nevils, 2011 WL 8144366 at *6 ("Although Missouri law prohibits subrogation by an insurer against an insured ... the Missouri Court of Appeals has stated that 'Missouri state law prohibiting subrogation is preempted by the FEHBA."). Other jurisdictions have followed Buatte with approval. See, *e.g.*, Thurman v. State Farm Mut. Auto Ins. Co., 598 S.E.2d 448, 451 (Ga. 2004); Aybar v. New Jersey Transit Bus Operations, Inc., 701 A.2d 932, 937 (N.J.Super A.D. 1997), citing Buatte, 939 S.W.2d at 442; NALC, 879 F.Supp. at 763; and Medcenters, 26 F.3d at 867) ("The State presents us with no case dealing with an anti-subrogation provision that holds such a provision is not preempted by FEHBA or ERISA.").

The doctrine of stare decisis directs that, once a court has "laid down a principle of law applicable to a certain state of facts, it [must] adhere to that principle, and apply it to all future cases, where facts are substantially the same; regardless of whether the parties and property are the same." BLACK'S LAW DICTIONARY 1406 (6th ed.1990); Eighty Hundred Clayton Corp. v. Director of Revenue, 111 S.W.3d 409, 412 (Mo.banc 2003). The doctrine of stare decisis promotes security in the law by encouraging adherence to previously decided cases. Independence-

Nat. Educ. Ass'n v. Independence Sch. Dist., 223 S.W.3d 131, 137 (Mo.banc 2007); Watts v. Lester E. Cox Medical Centers, 2012 WL 3101657 *10 (Mo.banc 2012).

Appellant maintains that the district court in Nevils suggested that Missouri courts may want to revisit Buatte's holding "in light of subsequent developments of the law, see, e.g., Blue Cross Blue Shield of Illinois v. Cruz, 495 F.3d 510 (7th Cir. 2007) (distinguishing between "benefits" and "financial incident[s]")." Nevils, 2011 WL 8144366 at *6. Cruz, however, is a federal case from the Seventh Circuit, applying Illinois law, and thus has no precedential value in Missouri. Our own precedent compels this Court to reject Appellant's argument on appeal, as the same argument has already been presented to and rejected by this Court in Buatte.

In any event, even after a careful examination of Cruz, we do not find any development sufficient to question our own holding in Buatte or to find that its holding is incorrect. In Cruz, the FEHBA health insurer sued the insured federal employee seeking reimbursement for benefits paid out of the insured's settlement with the tortfeasor causing his injuries. The United States Court of Appeals for the Seventh Circuit held that no federal-question jurisdiction existed in the insurer's suit against the employee, in response to which the employee asserted Illinois' common fund doctrine, which states that the insurer is responsible for a pro rata share of the employee's attorney's fees. The Court found no unique federal interest in whether the state's doctrine controlled over a contrary term of the insurance contract, since the doctrine affected how much of a tort settlement insured could keep, rather than the amount of bene-

fits he was entitled to. Cruz, 495 F.3d at 513. Thus, Cruz's only holding was that no federal jurisdiction existed over the case.[1]

In Buatte, this Court stated that prohibiting the insurer from seeking reimbursement for its medical coverage expenditures from its federal employee insured's tort suit proceeds based on Missouri's anti-subrogation rule would clearly affect the extent of coverage or benefits. Id. at 442. Although we did not state, in so many words, that the prohibition against subrogation would only affect "how much of the tort proceeds the insured could keep," rather than affect "how many benefits the insured would receive," the import of our words was the same as the import of the words used in Cruz. In the end, each of the insureds in Buatte and Cruz would be remitting some of his tort claim proceeds to his insurer. In Buatte, such remittitur was based on the insurance contract's subrogation clause's preemptive effect on Missouri's anti-subrogation law; and in Cruz, the reimbursement was based on tort proceeds being classified as incidentals rather than benefits and thus preemption over laws affecting benefits was inapplicable. Because Cruz's holding only concerned whether it had federal question jurisdiction and clearly acknowledged that its insured was not going to be able to retain all of his tort claim proceeds but would have to reimburse some to the insurer due to the insurance contract's subrogation clause, the Sev-

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[1] Although the Seventh Circuit distinguished between the word "benefits" as used in FEHBA's subrogation clause and the monies a plaintiff receives from a third-party tortfeasor, which the Court determined to be more appropriately characterized as "financial incidents," this appears to be a distinction without a difference because the Court's ultimate holding did not abrogate FEHBA's preemption of state anti-subrogation law.

enth Circuit's decision does not affect our holding in Buatte that FEHBA preempts Missouri's anti-subrogation law. Therefore, we find no compelling reason to change course from the general dictates of the doctrine of stare decisis and specifically our holding in Buatte. Med. Shoppe Intern., Inc. v. Dir. Of Revenue, 156 S.W.3d 333, 335 (Mo.banc 2005). A decision of this Court should not be lightly overruled, particularly where the opinion is not clearly erroneous and manifestly wrong. Southwestern Bell Yellow Pages, Inc. v. Director of Revenue, 94 S.W.3d 388, 391 (Mo.banc 2002); Eighty Hundred Clayton Corp., 111 S.W.3d at 412.

Appellant also maintains that the United States Supreme Court has likewise distinguished between benefits and reimbursement in Empire Healthchoice Assurance, Inc. v. McVeigh, 547 U.S. 677, 126 S.Ct. 2121, 2132, 165 L.Ed.2d 131 (2006). As in Cruz, the scenario in Empire involved a New York federal employee insured who had recovered damages for his injuries from a state court tort action. The insurer sought reimbursement from the insured's estate for the medical coverage it had provided the insured. The Empire court's holding was solely that federal question jurisdiction was lacking, in that the case did not arise under federal law nor did it involve issues of federal law that belonged in federal court; rather, the insurer's reimbursement claim was triggered not by the action of any federal department, agency, or service, but by the settlement of the personal injury action launched in state court. Empire, 126 S.Ct. 2121, 2129-2130, 2137 (The United States no doubt has an overwhelming interest in attracting able workers to the federal workforce and in the health and welfare of the federal workers upon whom it relies to carry out its functions, but those interests, we

are persuaded, do not warrant turning into a discrete and costly "federal case" an insurer's contract-derived claim to be reimbursed from the proceeds of a federal worker's state-court-initiated tort litigation.). Id. at 2137.

So, here, again, we are presented with the holding of a federal case applying federal law that does not bear upon our conclusion in Buatte, nor does it provide any pertinent or persuasive reasoning that would legitimize a revisit to or reconsideration of Buatte's holding. Rather, the Supreme Court in Empire was merely deciding a jurisdictional issue, which is not even tangentially related to our determination of preemption in Buatte. For these reasons, we reject Appellant's arguments on the basis of the Empire case as well.

Our holding in Buatte, that FEHBA preempts Missouri's anti-subrogation rule because the insurer's right to reimbursement of medical bill payments relates to the nature, provision or extent of benefits provided by the insurer to its federal employee insureds, remains valid. Appellant has failed to present any compelling reason to consider otherwise. Accordingly, his point on appeal is denied.

Conclusion

The judgment of the trial court is affirmed.

s/_____
Sherri B. Sullivan, Judge

Clifford H. Ahrens, P.J., and
Glenn A. Norton, J., concur.

APPENDIX E

SUPREME COURT OF MISSOURI
en banc

Jodie Nevils,	)	
	)	
Nevils,	)	
	)	
vs.	)	No. SC93134
	)	
Group Health Plan, Inc., and ACS Recovery Services, Inc.,	)	
	)	
Respondents.	)	

Appeal from the Circuit Court of St. Louis County
The Honorable Thea A. Sherry, Judge

Opinion issued February 4, 2014

Jodie Nevils (Appellant) filed suit against Group Health Plan, Inc., (GHP) and ACS Recovery Services, Inc., (ACS) (collectively Respondents) after Respondents enforced a subrogation lien against Nevils's settlement of a personal injury claim. The trial court, consistent with *Buatte v. Gencare Health Sys., Inc.*, 939 S.W.2d 440 (Mo. App. 1996), entered summary judgment in favor of Respondents on grounds that 5 U.S.C. section 8902(m)(1) of the Federal Employee Health Benefits Act ("FEHBA") preempts Missouri law prohibiting subrogation. Nevils asserts that FEHBA does not preempt state law barring subrogation of personal injury claims because subrogation does not "relate to the nature, provision, or extent of coverage or benefits." This Court holds that FEHBA does not preempt Missouri law barring subrogation

of personal injury claims. The judgment is reversed, and the case is remanded.

I. Facts

GHP entered into contracts with the federal Office of Personnel Management (OPM) to provide health insurance to federal employees pursuant to FEHBA. The contract directs GHP to seek reimbursement or subrogation when an insured obtains a settlement or judgment against a tortfeasor for payment of medical expenses. Nevils was a federal employee with medical insurance offered through a federal employee health benefit plan carried by GHP.

Nevils was injured in an automobile accident. GHP paid Nevils's resulting medical bills. Nevils then recovered a personal injury settlement from the tortfeasor responsible for the accident. GHP, through its agent ACS, asserted a lien against Nevils' settlement in the amount of $6,592.24, seeking reimbursement or subrogation for its payment of Nevils' medical bills resulting from the accident. Nevils satisfied the lien.

Nevils filed a class action petition for damages on behalf of himself and others similarly situated against GHP alleging violation of the Missouri Merchandising Practices Act; unjust enrichment; conversion; and seeking injunctive relief. All claims were based on the premise that Missouri law does not permit the subrogation of tort claims. GHP removed the case to federal court. Nevils filed a motion to remand the case to state court. The federal district court sustained Nevils' motion on the ground that there was no federal jurisdiction because *Buatte* held that the FEHBA preempts Missouri law barring subrogation.

Following remand to the state court, ACS intervened in the case. Respondents filed a motion for summary judgment. Respondents, relying on *Buatte*, asserted that FEHBA preempted Missouri's anti-subrogation law. The trial court entered judgment for Respondents. This appeal followed.

II. Standard of Review

Nevils' sole point on appeal asserts that the trial court erred in entering summary judgment in favor of Respondents because FEHBA does not preempt Missouri law barring subrogation of personal injury claims. This Court's standard of review for an appeal of a summary judgment regarding a legal issue is de novo. *ITT Commercial Fin. Corp. v. Mid-America Marine Supply Corp.*, 854 S.W.2d 371, 376 (Mo. banc 1993).

III. Analysis

Missouri law generally prohibits subrogation in personal injury cases by barring insurers from obtaining reimbursement from the proceeds an insured obtains following a judgment against a tortfeasor. *See Benton House, LLC v. Cook & Younts Ins., Inc.*, 249 S.W.3d 878, 882 (Mo. App. 2008). Subrogation in personal injury cases is considered to be against public policy because it amounts to an impermissible assignment of the insured's right to a cause of action for suffering a personal injury. *See Hays v. Mo. Highways & Transp. Comm'n*, 62 S.W.3d 538, 540 (Mo. App. 2001). Therefore, insurance policies with reimbursement or subrogation clauses are invalid under Missouri law. *Buatte*, 939 S.W.2d at 442.

Although Missouri law generally prohibits subrogation of personal injury claims, FEHBA's preemp-

tion clause, 5 U.S.C. section 8902(m)(1), applies to this case and provides:

> The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

Resolution of the issue in this case requires this Court to determine whether Respondents' asserted right to subrogation "relate[s] to the nature, provision or extent of coverage or benefits."

The Supremacy Clause of the United States Constitution provides that state laws and constitutional provisions are preempted when in conflict with federal laws. *See Johnson v. State*, 366 S.W.3d 11, 26-27 (Mo. banc 2012). Consideration of issues arising under the Supremacy Clause "start[s] with the assumption that the historic police powers of the States [are] not to be superseded by ... Federal Act unless that [is] the clear and manifest purpose of Congress." *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504 (1992). When a federal statute regulates an area that is traditionally subject to state authority, courts "should be reluctant to find preemption." *CSX Transp., Inc., v. Easterwood,* 507 U.S. 658, 664 (1993). Preemption analysis, therefore, "is informed by two presumptions about the nature of preemption." *City of Belton v. Smoky Hill Ry. & Historical Soc., Inc.,* 170 S.W.3d 429, 434 (Mo. App. 2005), quoting *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996). First, it is presumed that the states' historic police powers are not preempted unless it is the clear intent of Congress. *Id.* Second, a court's analysis of the scope of a stat-

ute's preemption is determined by the congressional purpose in enacting the statute. *Id.* When two plausible readings of a statute are possible, "we would nevertheless have a duty to accept the reading that dis-favors preemption." *Bates v. Dow AgroSciences, LLC,* 544 U.S. 431, 449 (2005).

In *Buatte*, the Missouri court of appeals held that FEHBA preempted Missouri's law against subrogation because the insurer's right to reimbursement of paid medical bills relates to the "nature, provision, or extent of coverage or benefits." *Buatte*, 939 S.W.2d at 442. The *Buatte* court reasoned that "prohibiting [the carrier] from seeking reimbursement would clearly differ the extent of coverage or benefits." *Id.* *Buatte* rested on the premise that subrogation "relates to" the insurance coverage and benefits. Other jurisdictions have followed the *Buatte* rationale. *See, e.g., Thurman v. State Farm Mut. Auto. Ins. Co.,* 278 Ga. 162, 598 S.E.2d 448, 451 (Ga. 2004); *Aybar v. New Jersey Transit Bus Operations, Inc.,* 305 N.J.Super. 32, 701 A.2d 932, 937 (N.J. 1997).

The continued validity of *Buatte* is called into question by the United States Supreme Court's decision in *Empire Healthchoice Assurance Co. v. McVeigh*, 547 U.S. 677, 698 (2006). In *Empire,* the Supreme Court held that the FEHBA preemption provision did not provide for complete preemption of state law so as to confer federal jurisdiction and, as a result, an insurance carrier's claims raised only state law issues. *Id.* The issue in *Empire* was whether FEHBA completely preempted state law in all insurance carrier disputes arising under the statute. Although the Supreme Court expressly declined to determine whether the statute preempts state subroga-

tion laws two aspects of the Supreme Court's analysis are relevant to Nevils' claim.

First, *Empire* recognized that the FEHBA preemption clause is subject to plausible, alternate interpretations. *Id.* at 697. The Supreme Court noted that the clause "was open to more than one construction" and its "words may be read to refer to contract terms relating to the beneficiary's entitlement (or lack thereof) to [the insurance plan's] payment for certain health-care services [the beneficiary] has received, and not to terms relating to the carrier's post-payments right to reimbursement." *Id.* at 698. The Supreme Court also noted that the "choice-of-law prescription is unusual in that it renders [superior] preemptive contract terms in health insurance plans, not provisions enacted by Congress[]" and that such an "unusual order warrants [a] cautious interpretation." *Id.* *Empire* establishes that the FEHBA preemption clause is susceptible to reasonable, alternate interpretations. The fact that the preemption clause is susceptible to alternate interpretations implicates the presumption against preemption noted in *Bates,* in which the Supreme Court noted that when two plausible readings of a statute are possible, "we would nevertheless have a duty to accept the reading that dis-favors preemption." *Bates,* 544 U.S. at 449 (2005).

Second, the Supreme Court distinguished the provision of insurance coverage and benefits to an insured from an insurer's right to subrogation. Specifically, the Supreme Court noted that while FEHBA contains a preemption clause displacing state law on issues relating to coverage and benefits, FEHBA "contains no provision addressing the subrogation or reimbursement rights of carriers." *Id.* at

683. This distinction is important because *Buatte* is premised on the conclusion that, pursuant to the FEHBA preemption clause, an insurer's contractual right to subrogation under a FEHBA insurance plan relates to "the nature, provision, or extent of coverage or benefits." If an insured's coverage and benefits are separate from the insurer's contractual right to subrogation, then the right to subrogation does not "relate to" coverage and benefits and state subrogation law is not preempted.

The distinction between insurance benefits and subrogation was further explained in *Blue Cross Blue Shield of Illinois v. Cruz*, 495 F.3d 510 (7th Cir.2007), where the court noted that *Empire* "distinguished ... between benefits and reimbursement" and reasoned that the amount of benefits to which an insured is entitled is established by the insurance contract while state law regarding subrogation simply affects the amount of a tort judgment the plaintiff gets to keep and how much he or she must give the insurer. *Id.* at 512. Following this rationale, the court then noted that if the term "benefits" as used in the FEHBA preemption clause is understood to include every financial incident of an illness or injury, then "national uniformity is unattainable without a federal takeover of the entire tort system." *Blue Cross Blue Shield of Ill. v. Cruz ("Cruz II")*, 495 F.3d 510, 514 (7th Cir. 2007).

Empire and *Cruz* are not dispositive because both cases held only that there was no federal jurisdiction arising from complete preemption of state law. As noted above, however, *Empire* counsels a "cautious" interpretation of the FEHBA preemption clause and both cases established a distinction between the insured's coverage and benefits and the

insurer's right to subrogation. In addition to the presumption against preemption, this Court's analysis of whether FEHBA preempts Missouri's law of subrogation must assess GHP's right to subrogation with these considerations in mind.

The FEHBA preemption clause provides that contract terms that "relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)" preempt state law. The operative terms are "relate to," "coverage" and "benefits." *See Kobold v. Aetna Life Ins., Co.*, 309 P.3d 924, 927 (Ariz. App. 2013)(holding that FEHBA does not preempt Arizona law barring subrogation of personal injury claims).

The term "relate to" generally means "having a connection with." *Kobold*, 309 P.3d at 927, citing, *Botsford v. Blue Cross & Blue Shield of Mont., Inc.*, 314 F.3d 390, 394 (9th Cir. 2002)(interpreting latter half of the FEHBA preemption clause, which provides for preemption of any state law that "relates to" health insurance or plans). When considered in conjunction with *Empire's* "cautious interpretation" and the presumption against preemption, the term "relate to" cannot be given a broad, literal interpretation.[1] A broad interpretation of "relate to" would "extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for 'really, universally, relations stop nowhere.'" *Kobold*, 309 P.3d at 927, citing *Roach v. Mail Handlers Benefit Plan*, 298 F.3d 847,

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[1] The presumption against preemption and the attendant requirement of a more narrow interpretation distinguishes the analysis in this case from broader interpretations of the term "relate to" that may be utilized in cases involving a remedial statute.

849-50 (9th Cir. 2002) (quoting *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995)). The term "relate to," therefore, must be construed as requiring a direct and immediate relationship to the insurance coverage and benefits at issue. *Kobold*, 309 P.3d at 927.

The term "coverage" means the scope of the risks insured under a plan or policy. Black's Law Dictionary 394 (8th ed. 2004) (defining "coverage" as "[i]nclusion of a risk under an insurance policy; the risks within the scope of an insurance policy"). Therefore, the extent of Nevils' "coverage" consists of the various risks GHP agreed to insure. Nothing in the subrogation provision in the insurance contract affects the extent of insurable risk that GHP accepted. Further, subrogation necessarily occurs after the "coverage" issue is resolved, so subrogation cannot affect the extent, nature or provision of insurance "coverage." The scope of Nevils' insurance coverage is neither expanded nor curtailed by requiring him to reimburse GHP from the proceeds of Nevils' personal injury settlement. As such, subrogation does not relate to GHP's "coverage" of Nevils' risk of illness or accident. *See Kobold*, 309 P.3d at 928.

Finally, the term "benefits" means the financial assistance that the insured receives as a consequence of the coverage. Black's Law Dictionary 167 (defining "benefit" as "[f]inancial assistance that is received from ... insurance ... in time of sickness, disability, or unemployment"). As noted in *Empire* and *Cruz*, an insured's "benefits" are distinct from the insurer's right to pursue subrogation against the insured's recovery from a third party tortfeasor. In this context, the term "benefits" includes payments by the insurance carrier on behalf of the insured, not

payments to the insured by third parties. The "benefits" to which Nevils was entitled under the insurance plan provided by GHP were not dependent on recovery from a third party. The fact that GHP's contractual right to reimbursement is triggered by the payment of benefits does not mean that it "relate[s] to the nature, provision, or extent of" benefits. *Kobold*, 309 P.3d at 928. This is illustrated, in part, by the fact that Nevils would have been entitled to the same benefits had he never filed suit to recover damages for his injuries. *Id.* GHP's right to subrogation affects the parties' net financial position after the provision of insurance benefits pursuant to the coverage provided in the insurance contract, but it does not affect the scope of coverage or the receipt of benefits. The fact that GHP's contractual right to reimbursement is triggered by the payment of benefits does not mean that it "relate[s] to the nature, provision, or extent of" benefits. *Id.*, citing *Cruz*, 495 F.3d at 514.

The subrogation provision in favor of GHP creates a contingent right to reimbursement and bears no immediate relationship to the nature, provision or extent of Nevils' insurance coverage and benefits. Contrary to the holding in *Buatte,* this Court holds that FEHBA does not preempt Missouri law barring

subrogation of personal injury claims.[2] The judgment is reversed, and the case is remanded.

Richard B. Teitelman, Judge

Russell, C.J., Fischer, Stith and Draper, JJ., concur; Wilson, J., concurs in separate opinion filed; Breckenridge, J., concurs in opinion of Wilson, J.

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[2] Respondents also assert that an OPM "carrier letter" issued in June 2012 is entitled to "substantial deference" pursuant to *Chevron USA, Inc., v. Natural Resources Defense Counsel, Inc.*, 467 U.S. 837 (1984). The OPM letter reiterates the agency's position that FEHBA preempts state anti-subrogation rules. Under *Chevron*, an agency has the power to form policy and make necessary rules when the statute is either silent or ambiguous on an issue. *Id.* 842-43. However, "*Chevron* deference" is typically applied "where an agency rule sets forth important rights and duties, where the agency focuses fully and directly on the issue, where the agency uses notice and comment procedures to promulgate a rule, [and] where the resulting rule falls within the statutory grant of authority." *Long Island Care at Home, Ltd. v. Cole*, 551 U.S. 158, 173 (2007). The OPM carrier letter is recent, informal and was drafted in response to litigation challenging the subrogation provision in its contract. While informal agency interpretations of statutes are relevant, there is no indication that Congress delegated to the OPM the authority to make binding interpretations of the scope of the FEHBA preemption clause. The OPM letter is not entitled to the deference described in *Chevron* and does not establish that FEHBA preempts state anti-subrogation law. *See Kobold*, 309 P.3d at 929.

SUPREME COURT OF MISSOURI

en banc

Jodie Nevils,	)	
	)	
Appellant,	)	
	)	
vs.	)	No. SC93134
	)	
Group Health Plan, Inc., and ACS Recovery Services, Inc.	)	
	)	
Respondents.	)	

CONCURRING OPINION

Missouri law prohibits a health care insurer from demanding that the insured repay benefits received before the insured recovers from his tortfeasor. GHP contends that Jodie Nevils lost the protection of Missouri law in this regard when he went to work for the federal government. GHP's argument is based on the language of the Federal Employee Health Benefits Act ("FEHBA"), 5 U.S.C. § 8902(m)(1), which purports to subordinate certain aspects of Missouri law not to any federal law but to contract terms negotiated between GHP and the federal Office of Personnel Management ("OPM").

The majority opinion concedes the preemptive power asserted in § 8902(m)(1) and so rejects GHP's argument only by finding that the benefit repayment terms in GHP's contract fail the relatedness test set forth in that statute. I disagree because the conclusion that contract terms requiring Nevils to repay benefits already received are not related to the nature and extent of Nevils' benefits (and are not relat-

ed to payments regarding his benefits) is based on the sort of hyper-technical approach that this Court otherwise steadfastly refuses to employ when construing insurance contracts. I do not dissent, however, because I would hold that the preemption language in § 8902(m)(1) is not a valid application of the supremacy clause in article VI of the Constitution of the United States; as a result, it has no effect. Accordingly, FEHBA presents no bar to Nevils' suit, and I concur with the majority opinion that the trial court judgment should be vacated and the case remanded for further proceedings.[1]

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[1] GHP earlier attempted to remove this case to federal court under 28 U.S.C. § 1441 (federal question removal) because Nevils' claims arise under federal law and under 28 U.S.C. § 1442(a)(1) (federal officer removal) because GHP was acting at the direction of OPM in requiring Nevils to repay the GHP benefits he had received. The district court denied both grounds and remanded the case to state court. *Nevils v. Group Health Plan, Inc.*, No. 4:11 CV 588 DDN (E.D.Mo. June 15, 2011) (2011 WL 8144366). However, the district court's reasoning regarding federal officer removal later was rejected by the Eighth Circuit, which found removal proper because insurers exercise delegated authority under FEHBA. *Jacks v. Meridian Res. Co., LLC*, 701 F.3d 1224, 1234 (8th Cir. 2012) (citing and rejecting district court's decision in *Nevils*). And, on the second ground, the district court denied removal under the federal question statute because "Missouri law presently does not appear to conflict with the operation of the OPM–GHP Contract." *Nevils*, 2011 WL 8144366 at *6 (citing *Buatte v. Gencare Health Sys., Inc.*, 939 S.W.2d 440 (Mo. App. 1996)). Though the district court foretold that *Buatte* would be overruled as wrongly decided, it held that federal jurisdiction could not be premised on the possibility that a conflict between state and federal law might arise later in the case. *Id.* But now that this Court has overruled *Buatte*, federal question jurisdiction may exist. In rejecting federal court jurisdiction in *McVeigh*, the Supreme Court was careful to restrict its determination to the procedural con-

I. Background

Nevils was injured in a car wreck and, as a result, incurred medical bills in excess of $6,600. Those bills were paid by GHP, which managed the health insurance plan for Nevils and other federal employees in Missouri according to terms negotiated between GHP and the "OPM".[2] When Nevils later

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text before it, i.e., where the insurer sued to enforce its contractual right to subrogation. The Court held that such a claim involved no rights established by Congress or federal common law and that a federal question would arise, if at all, only as a defense to the insurer's claim. Under the "well pleaded complaint" rule, federal question jurisdiction cannot be predicated on an anticipated federal defense. But here, even though Nevils is asserting state law claims, a necessary element of his claims is that GHP had no right to the reimbursement it demanded and obtained. That element plainly depends upon the application (and validity) of § 8902(m)(1). This question of federal law is an essential part of Nevils' claims, not merely an anticipated defense.

[2] GHP is not an insurer in the ordinary sense because it bears no risk regarding Nevils' health care plan. Instead, all of the risk is borne by the United States, and GHP merely manages the plan for a fee. *Empire Healthchoice Assur., Inc. v. McVeigh*, 547 U.S. 677, 703 (2006) (Breyer, J., dissenting). GHP's management duties are set out in its contract with OPM, and this contract also establishes the nature and extent of the employee benefits provided, as well as the circumstances in which the employee must repay those benefits. *Id.* The premiums paid by the government and its employees are held by the United States, not GHP, and are used to pay claims processed by GHP and the other third-party managers ("TPMs"). The proceeds of the benefit repayment terms at issue in this case, and those from similar terms allowing GHP to pursue an enrollee's claims as a subrogee, are not retained by GHP. Instead, they are paid into this same fund and used by the United States to cover premium shortfalls, rebate premiums already paid, reduce future premiums, or increase plan benefits. *Id.* Oddly, GHP does not argue that its role as a TPM (and not as an in-

settled his claim against the driver whose negligence caused Nevils' injuries, GHP demanded that Nevils repay the $6,600 so that GHP did not end up having to pay – and Nevils did not end up receiving – the benefits promised under the plan. Nevils repaid the $6,600.

If Nevils had been paying for health care coverage from GHP while working for any employer in Missouri other than the federal government, GHP would not have been allowed to reduce Nevils' benefits by $6,600 merely because he recovered from his tortfeasor. All parties agree that Missouri law renders void as a matter of public policy any contract provision purporting to give the insurer the right to such repayment. *See, e.g., Schweiss v. Sisters of Mercy*, 950 S.W.2d 537, 538 (Mo. App. 1997) (rejecting as "a distinction without a difference" the argument that "the reimbursement provision at issue in this case is different from [a subrogation provision] because it involves the assignment of the *proceeds*, not an assignment of the *claim*.") (emphasis in the original).[3]

But, in this case, GHP contends that the shoe is on the other foot. Here, GHP claims that it is the

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surer) should have any affect on the analysis. Nor does GHP argue that the repayment terms at issue here should be treated as benefiting – and, therefore, should be treated as being exercised by – the United States and not GHP.

[3] The Supreme Court, too, refused to distinguish between terms requiring subrogation and terms requiring employees to repay benefits received before the employee recovered from a third party. *McVeigh*, 547 U.S. at 693 (noting that federal common law could not displace state tort law governing an insurer's subrogation claim against the tortfeasor and finding no reason "why the two linked provisions – reimbursement and subrogation – should be decoupled").

terms of its contract with OPM that render Missouri law void, not the other way around. GHP's argument is based upon a provision in FEHBA that governs Nevils' health insurance plan:

> The ***provisions of any contract under this chapter*** which relate to the nature or extent of coverage or benefits (including payment with respect to benefits) ***shall supersede and preempt any State or local law***, or any regulation issued thereunder, which relates to health insurance or plans.

5 U.S.C. § 8902(m)(1) (emphasis added).[4]

II. § 8902(m)(1) applies and purports to preempt applicable Missouri law

The majority opinion concedes that, under § 8902(m)(1), the benefit repayment terms in GHP's contract "supersede and preempt" Missouri's law prohibiting them if – but only if – those terms "relate to the nature or extent of [Nevils'] coverage or benefits (including payment with respect to [his] benefits)." Accordingly, the majority opinion preserves the primacy of Missouri law only by declaring that benefit repayment terms have no relationship to the nature or extent of Nevils' benefits and no relationship to payments regarding his benefits. No matter how lenient the "blush test," this construction cannot pass muster.

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[4] A final clause reading: "to the extent that such law or regulation is inconsistent with such contractual provisions," was removed by Congress in 1998. Accordingly, "under § 8902(m)(1) as it now reads, ***state law*** – whether consistent or inconsistent with federal [contract terms] – ***is displaced on matters of 'coverage and benefits.'***" *Empire HealthChoice Assur., Inc. v. McVeigh*, 547 U.S. 677, 686 (2006) (emphasis added).

The majority opinion's construction of the GHP contract uses the type of form-over-substance approach that this Court ordinarily disdains when construing insurance contracts. Here, one part of the GHP contract plainly promises Nevils certain benefits (i.e., payment for covered medical expenses) while another part of the contract takes those benefits away by requiring him to repay these benefits if Nevils later recovers from a third party. This is the classic "give with one hand and take with the other" approach this Court ordinarily decries as a patent ambiguity. *See Behr v. Blue Cross Hosp. Serv., Inc., of Missouri*, 715 S.W.2d 251, 256 (Mo. banc 1986) ("If a contract promises something at one point and takes it away at another there is an ambiguity.") (citing *Lutsky v. Blue Cross Hospital Serv. Inc.*, 695 S.W.2d 870, 875 (Mo. banc 1985)). *See also Todd v. Missouri United Sch. Ins. Council*, 223 S.W.3d 156, 163 (Mo. banc 2007) (noting that *Behr* and *Lutsky* "involved contracts containing contradictory or necessarily inconsistent language in different portions of the instrument").

Leaving aside for the moment the issues of preemption and Missouri's prohibition against benefit repayment terms, if this suit was an action like *McVeigh* in which GHP sought to enforce its contractual right to repayment from Nevils, the Court surely would conclude that GHP's contract contains contradictory and conflicting terms, just as it did in *Behr* and *Lutsky*. Because terms cannot contradict or conflict one another unless they relate to the same subject, it defies logic to insist that benefit repayment terms do not ***relate*** to the nature or extent of Nevils' benefits. But even if that debate continues, surely everyone would concede that terms requiring Nevils to ***pay*** benefits back to GHP that GHP previously

had ***paid*** out are terms that relate to "payment with respect to [Nevils'] benefits."

The alternative conclusion that benefit repayment terms are unrelated to benefits because performance of the latter usually is complete before the former are invoked can only be correct as a purely academic exercise. *See Blue Cross Blue Shield of Illinois v. Cruz*, 495 F.3d 510, 514 (7th Cir. 2007) ("the *benefits* are uniform, though the net financial position of an insured who has a potential tort claim is not") (emphasis in original). But this Court usually does not adopt such a stilted construction. *See Seeck v. Geico Gen. Ins. Co.*, 212 S.W.3d 129, 132 (Mo. banc 2007) (when "construing the terms of an insurance policy, this Court applies the meaning which would be attached by an ordinary person of average understanding if purchasing insurance") (quotation marks omitted); *Robin v. Blue Cross Hosp. Serv., Inc.*, 637 S.W.2d 695, 698 (Mo. banc 1982) ("language used [in insurance contract] will be viewed in light of the meaning that would ordinarily be understood by the layman who bought and paid for the policy") (quotation marks omitted). Here, any ordinary insured would understand that benefit repayment terms are ***related*** to benefits because he does not care what his "benefits" are if he will not be allowed to keep them. As the Court recognized in *Behr* and *Lutsky*, the insured is concerned with the combined effect of conflicting terms. In other words, to the insured, it is not what you get that matters but what you get to keep.

Of course, this suit is not like *McVeigh*. It was initiated by Nevils, not GHP. After repaying the $6,600 in benefits previously received, Nevils brought common law and statutory consumer fraud

claims against GHP based upon its demand that Nevils (and a purported class of other insureds) make the repayments that GHP's contract plainly requires but that Missouri law ordinarily does not allow. But if the terms are related to benefits or payments – and plainly these are – they are related, regardless of which party wants (or does not want) them to be. Accordingly, I cannot join the reasoning of the majority opinion and would hold, instead, that the benefit repayment terms in GHP's contract plainly are related to the nature and extent of Nevils' benefits and, even more plainly, are related to "payment with respect to [Nevils'] benefits" because these terms actually require such a payment.

The majority opinion may have been persuaded by GHP's argument that the Supreme Court's decision in *McVeigh* suggests that the relationship between benefit repayment terms and benefits (or benefit payments) is uncertain and, therefore, not clear enough to overcome the presumption against preemption. This is not what *McVeigh* says, nor is it what this case means. *McVeigh* was concerned with whether federal courts have jurisdiction over a FEHBA insurer's contractual right to a benefit repayment, not with whether § 8902(m)(1) applies to such contract terms and preempts state laws that would prohibit them. Accordingly, the analysis in *McVeigh*, including the analysis on which GHP relies, occurs solely in the context of 29 U.S.C. § 1331 and whether that insurer had shown "either that federal law creates the [insurer's] cause of action or that the [insurer's] right to relief necessarily depends on resolution of a substantial question of federal law." *Id.* at 690 (quotation marks omitted).

The Supreme Court noted that nothing in FEHBA creates – or even mentions – the insurer's right to demand repayment of benefits. *Id.* at 696-97 (insurer's claim based solely on contract terms, not FEHBA). Thus, not only did the insurer's claim not arise out of FEHBA or any other federal statute, it also did not depend on the resolution of a federal law question.[5] Accordingly, if federal jurisdiction were to exist in *McVeigh*, it would only be because the insurer's claim arose under (and was controlled by) previously undetected federal common law in the area of federal employee health benefits so pervasive the

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[5] Under the "well-pleaded complaint" rule, federal court jurisdiction cannot be based on federal questions that are not raised by the plaintiff and will arise (if at all) only as a result of the defendant's answer. *Caterpillar Inc. v. Williams*, 482 U.S. 386, 392-93 (1987). Therefore, in *McVeigh*, it was irrelevant for jurisdictional purposes that the insured likely would defend the insurer's repayment claim by asserting New York's prohibition of such terms in insurance contracts, even though that would result in a debate over whether § 8902(m)(1) preempts the insured's state law defense. This reasoning does not apply here, however, because this case was brought by Nevils, not the insurer. GHP's earlier efforts to remove this case were unsuccessful because the district court found that Nevils' claim did not depend on the resolution of a disputed federal issue because "Missouri law presently does not appear to conflict with the operation of the OPM–GHP Contract." *Nevils v. Group Health Plan, Inc.*, No. 4:11 CV 588 DDN (E.D.Mo. June 15, 2011) (2011 WL 8144366, at *6) (citing *Buatte*). Now that *Buatte* has been overruled, however, the inapplicability (or invalidity) of § 8902(m)(1) is a federal law question essential to Nevils' claims and not just to an anticipated defense, as in *McVeigh*. In addition, the district court's rationale for rejecting GHP's alternative removal claim under 28 U.S.C. § 1442(a)(1) has been rejected by the Eighth Circuit. *See Jacks v. Meridian Res. Co., LLC*, 701 F.3d 1224, 1234 (8th Cir. 2012) (citing and rejecting district court's decision in *Nevils*).

Supreme Court reasonably could infer that Congress intended to allow federal court jurisdiction.

Accordingly, the only purpose for which *McVeigh* considers § 8902(m)(1) is to see whether that statute supports an inference that Congress intended to overthrow not just isolated aspects of state law but the entire body of state law that may affect federal employee health benefits. The Supreme Court found the statute inadequate for this purpose.

> [§ 8902(m)(1)] is not sufficiently broad to confer federal jurisdiction. If Congress intends a preemption instruction completely to displace ordinarily applicable state law, and to confer federal jurisdiction thereby, it may be expected to make that atypical intention clear. Congress has not done so here.

Id. at 698.

The Court later reaffirmed this holding, stating that the insurer failed to "establish that § 8902(m)(1) leaves no room for any state law potentially bearing on federal employee-benefit plans in general, or carrier-reimbursement claims in particular" and, therefore, "§ 8902(m)(1) [contains] no prescription for federal-court jurisdiction." *Id.* at 699 (emphasis added). *See also Empire HealthChoice Assur., Inc. v. McVeigh*, 396 F.3d 136, 150 (2d Cir. 2005) *aff'd.* 547 U.S. 677 (2006) ("The preemption provision [§ 8902(m)(1)] does not manifest an intent to supplant all state law with federal common law in cases involving FEHBA-authorized contract provisions.")

In light of the context in which the Supreme Court was evaluating § 8902(m)(1), it is clear that the Court's statements regarding the uncertain reach of the statute had nothing to do with whether the

Court believed Congress intended for contractual benefit repayment terms to preempt state law prohibitions of such terms. Instead, those statements reflected only the Court's conclusion that § 8902(m)(1) fails to demonstrate any clear congressional intent to replace the entire body of state law with federal common law. To suggest, as GHP does, that the Supreme Court was indicating that the statute may not apply to benefit repayment terms is a misuse of *McVeigh*.[6]

For the reasons stated above, I would hold that Congress plainly intended for § 8902(m)(1) to give preemptive effect to contract terms between OPM and private insurance companies so that terms that

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[6] GHP's reliance on *Blue Cross Blue Shield of Illinois v. Cruz*, 495 F.3d 510 (7th Cir. 2007), also is misplaced. The majority opinion quotes *Cruz* as saying that the Supreme Court in *McVeigh* "distinguished ... between benefits and reimbursement." *Id.* at 513. But *Cruz* makes this comment in the context of recounting the Supreme Court's fruitless search for a basis to infer that Congress intended to displace the entire body of state law in this area with federal common law. The two sentences in *Cruz* immediately before the sentence quoted in the majority opinion make this clear:

> The jurisdictional holding in our previous opinion was based on a belief that Congress in the Federal Employees Health Benefit Act had wanted federal employees to have ***the same benefits under their health plan no matter what state they were in***, so that if they moved from one state to another they would not have to worry that their entitlement had changed. ***That was an argument for regulating the contracts between the insurers and the government by a uniform body of contract principles, and thus by a federal common law of contracts.*** The Supreme Court distinguished, however, between benefits and reimbursement.

Id. at 513 (emphasis added).

require federal employees to repay health insurance benefits received before the employee recovers from the tortfeasor will "supersede and preempt" state laws prohibiting such terms.[7]

III. § 8902(m)(1)'s attempt at preemption is ineffective

Even though Congress plainly intended for § 8902(m)(1) to apply to the benefit repayment terms in GHP's contract and give such terms preemptive effect, I do not concede that Missouri law must bow to those terms. The idea that Congress claims the power to authorize the executive branch and private insurance companies to negotiate contract terms that Congress decrees – sight unseen – shall "preempt and supersede" state law is such an unprecedented and unjustified intrusion on state sovereignty that it almost defies analysis. *See Arthur D. Little, Inc. v. Comm'r of Health & Hospitals of Cambridge*, 481 N.E.2d 441, 452 (Mass. 1985) ("this court has been unable to locate authority in this or any other jurisdiction which supports the proposition that a contract to which the Federal government is a party

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[7] To be clear, I would hold that benefit repayment terms not only meet the relatedness test in § 8902(m)(1) in that they relate to the nature or extent of Nevils' benefits (and to payments regarding his benefits), I would hold that Missouri's prohibition against such terms meets the statute's second test requiring that the state law being preempted must "relate[] to health insurance or plans." Nevils does not contest the applicability of this second test, nor could he. Missouri's common law prohibition against terms giving insurers a right to repayment of benefits may be based in the broader policy against subrogation or assignment of personal injury claims, but this well-established prohibition applies directly – not merely incidentally – to "health insurance or plans."

somehow constitutes Federal law for the purposes of the supremacy clause").

To be sure, the supremacy clause declares that "the laws of the United States ... shall be the supreme law of the land; and the judges in every state shall be bound thereby, ***anything in the constitution or laws of any state to the contrary notwithstanding***." U.S. Const. Art. VI, cl. 2 (emphasis added). This Court's duty to uphold the constitution and laws of ***both*** the United States and the State of Missouri mandates that, when the latter conflicts with the former, this Court must apply the supremacy clause and federal law will prevail.

But the supremacy clause assigns primacy solely to federal ***law***. It does not provide – or even suggest – that the terms of a contract between the federal government and a private insurance company can override Missouri law regarding what terms are (and are not) permitted in contracts covering Missouri employees and their families. Accordingly, to the extent Congress sought to give preemptive effect to the benefit repayment terms in GHP's contract – and there is no doubt that this is what 5 U.S.C. § 8902(m)(1) does – the supremacy clause does not authorize that effort.

Associate Justice Sotomayor, while a judge on the United States Court of Appeals for the Second Circuit, authored the *McVeigh* decision that was affirmed by the Supreme Court. There, then-Judge Sotomayor noted that, even though federal courts (like the majority opinion in this case) "generally decide FEHBA cases as if § 8902(m)(1) were a preemption provision like any other, the provision is in fact quite unusual, because it provides that certain types of *contract terms* will 'supersede and preempt' state

laws in a particular field." *McVeigh*, 396 F.3d at 143 (emphasis in original).

Despite the graciously judicial understatement in which she characterizes FEHBA as "unusual" in this regard, then-Judge Sotomayor explained that the plain language of FEHBA's preemption provision is unconstitutional:

> Normally, preemption clauses provide that federal *law* will preempt state law. A typical provision might provide for preemption, for example, by expressly stating that the statute's provisions preempt state law, or by prohibiting state law from interfering with a policy established in federal law. Regardless of a given provision's structure or wording, however, ***we generally take for granted that it is law, and not a mere contract term, that carries the preemptive force***.
>
> Though § 8902(m)(1)'s plain language differs from typical preemption provisions by unambiguously providing for preemption by contract, such ***a literal reading of the provision is highly problematic, and probably unconstitutional***, because only federal *law* may preempt state and local law. The constitutionality of federal preemption is, after all, grounded in the Supremacy Clause of the Constitution, which provides that "*the Laws of the United States* ... shall be the supreme Law of the Land ... any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." U.S. Const. Art. VI, cl. 2. (emphasis added). ***There is no constitutional basis for making the terms of con-***

> ***tracts with private parties similarly "supreme" over state law.***
>
> ***Taken literally, therefore, FEHBA's preemption provision may fail to withstand constitutional scrutiny unless FEHBA-authorized contracts themselves are "Laws of the United States." They are not.*** "Law" connotes a policy imposed by the government, not a privately-negotiated contract. Under FEHBA, the government does not impose contract terms as it would impose a law. Rather, the OPM negotiates the contract terms privately with insurance providers, who are under no obligation to enter into the contracts in the first place. Empire's attempt to portray FEHBA contracts as "law" is unavailing.

Id. at 143-44 (citations omitted) (emphasis in the original, bold emphasis added).

The Second Circuit in *McVeigh* did not strike down § 8902(m)(1) as unconstitutional, however. Then-Judge Sotomayor explained that a "saving" construction might cure the statute's patent constitutional defects:

> Here, we can reasonably construe § 8902(m)(1) as requiring that, in cases involving the "terms of any contract under [FEHBA] which relate to the nature, provision, or extent of coverage or benefits," *federal law* "shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." 5 U.S.C. § 8902(m)(1). This construction is as faithful as constitutionally

> possible to the provision's plain language and respects Congress's stated intent to maintain "uniformity" in FEHBA benefits and to "displace State or local law relating to health insurance or plans." ***The federal law preempting state law may be federal common law or the FEHBA statute provisions themselves, but it must be law—not contract terms.***

Id. at 144-45 (citations omitted) (emphasis in the original, bold emphasis added).

I agree with the analysis conducted by then-Judge Sotomayor and with her conclusion that there "is no constitutional basis for making the terms of contracts with private parties similarly 'supreme' over state law." *Id.* at 143. Accordingly, I would hold that Congress's attempt in § 8902(m)(1) to give GHP's contractual benefit repayment terms preemptive effect over Missouri's law prohibiting such terms is not a valid exercise of the power embodied in the supremacy clause and, as a result, the terms of GHP's contract no more "supersede and preempt" Missouri law than do the terms of any wholly private contract.

After respectful consideration, there is no basis for adopting the saving construction offered by then-Judge Sotomayor. First, as then-Judge Sotomayor later explained, both her analysis of the constitutional infirmities of § 8902(m)(1) and her proposed saving construction were not holdings. *Empire HealthChoice Assur., Inc. v. McVeigh*, 402 F.3d 107, 110 (2d Cir. 2005) (petition for rehearing denied). Second, even assuming that the proposed reading "saves" § 8902(m)(1), it is not a valid "construction" of that statute. Instead, it is a material rewrite that

creates a result not only different from that which Congress plainly intended but almost antithetical to it. Congress is well aware of federal common law and the types of statutory frameworks that have been used to justify it. Congress refused to take any of these approaches with § 8902(m)(1) but chose instead the apparently unprecedented path of attempting to assign preemptive force to the terms agreed upon by OPM and its contractual partners. Accordingly, it appears that Congress not only wanted to wrest power over federal employee health care benefits away from the states, but it also was unwilling to cede that power to the courts in the form of a "blank check" authorization to create federal common law.

The final reason to reject the saving construction offered in *McVeigh*, 396 F.3d at 144-45, is that the Supreme Court thoroughly and completely rejected any argument that § 8902(m)(1) implicitly authorizes federal courts to supplant state law with common law of their own making. *McVeigh*, 547 U.S. at 698-99. Then-Judge Sotomayor may have taken a different path than the Supreme Court, but she reached the same conclusion concerning federal common law despite her proposed savings construction of the statute. *McVeigh*, 396 F.3d at 150 (nothing in § 8902(m)(1) "manifest[s] an intent to supplant all state law with federal common law in cases involving FEHBA-authorized contract provisions").

IV. Conclusion

For the reasons set forth above, I disagree with the rationale employed by the majority opinion, but I concur in the majority opinion's conclusion that the

trial court's judgment must be vacated and the case remanded for further proceedings.[8]

Paul C. Wilson, Judge

[8] The trial court entered judgment for GHP (and its agent, ACS) solely on the basis of *Buatte*. That judgment is now vacated on the ground that § 8902(m)(1) does not apply or – as I would hold – it is not a valid exercise of preemption under the supremacy clause. However, neither the majority opinion nor this concurrence analyze whether the trial court's summary judgment should be affirmed on the alternative grounds raised by GHP in its motion. For example, even assuming that Nevils' consumer fraud claim states a claim for relief notwithstanding GHP's reliance on the express terms of its federal contract, on § 8902(m)(1), and on *Buatte*, such a claim may be barred by section 407.020(2), which exempts from chapter 407 all companies subject to licensure by the department of insurance. However, unless it is clear as a matter of law that none of the pleaded claims can state a claim against any defendant, the better course is to remand the case for further proceedings. *See Hoover v. Mercy Health*, 408 S.W.3d 140, 143 (Mo. banc 2013).

APPENDIX F

Supreme Court of the United States

No. **13-1305**

COVENTRY HEALTH CARE OF MISSOURI, INC., fka GROUP HEALTH PLAN, INC.,

Petitioner

v.

JODIE NEVILS

ON PETITION FOR WRIT OF CERTIORARI to the Supreme Court of Missouri.

THIS CAUSE having been submitted on the petition for writ of certiorari and the response thereto.

ON CONSIDERATION WHEREOF, it is ordered and adjudged by this Court that the petition for writ of certiorari is granted. The judgment of the above court in this cause is vacated with costs, and the cause is remanded to the Supreme Court of Missouri for further consideration in light of new regulations promulgated by the Office of Personnel Management (OPM). See OPM, *Final Rule, Federal Employees Health Benefits Program; Subrogation and Reimbursement Recovery*, 80 Fed. Reg. 29,203 (May 21, 2015) (5 C.F.R. 890.106).

IT IS FURTHER ORDERED that the petitioner Coventry Health Care of Missouri, Inc., fka Group Health Plan, Inc. recovers from Jodie Nevils Three Hundred Dollars ($300.00) for costs herein expended.

June 29, 2015

Clerk's costs: $300.00

A True copy SCOTT S. HARRIS

Test

Clerk of the Supreme Court of the United States

By: s/

APPENDIX G

U.S. Const. art. VI, cl. 2

This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

5 U.S.C. § 8901. Definitions

For the purpose of this chapter—

(1) "employee" means—

(A) an employee as defined by section 2105 of this title;

(B) a Member of Congress as defined by section 2106 of this title;

(C) a Congressional employee as defined by section 2107 of this title;

(D) the President;

(E) an individual first employed by the government of the District of Columbia before October 1, 1987;

(F) an individual employed by Gallaudet College;[1]

(G) an individual employed by a county committee established under section 590h(b) of title 16;

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[1] So in original. Does not conform to section catchline.

[1] See Change of Name note below.

(H) an individual appointed to a position on the office staff of a former President under section 1(b) of the Act of August 25, 1958 (72 Stat. 838);

(I) an individual appointed to a position on the office staff of a former President, or a former Vice President under section 4 of the Presidential Transition Act of 1963, as amended (78 Stat. 153), who immediately before the date of such appointment was an employee as defined under any other subparagraph of this paragraph; and

(J) an individual who is employed by the Roosevelt Campobello International Park Commission and is a citizen of the United States,

but does not include—

(i) an employee of a corporation supervised by the Farm Credit Administration if private interests elect or appoint a member of the board of directors;

(ii) an individual who is not a citizen or national of the United States and whose permanent duty station is outside the United States, unless the individual was an employee for the purpose of this chapter on September 30, 1979, by reason of service in an Executive agency, the United States Postal Service, or the Smithsonian Institution in the area which was then known as the Canal Zone;

(iii) an employee of the Tennessee Valley Authority; or

(iv) an employee excluded by regulation of the Office of Personnel Management under section 8913(b) of this title;

(2) "Government" means the Government of the United States and the government of the District of Columbia;

(3) "annuitant" means—

(A) an employee who retires—

(i) on an immediate annuity under subchapter III of chapter 83 of this title, or another retirement system for employees of the Government, after 5 or more years of service;

(ii) under section 8412 or 8414 of this title;

(iii) for disability under subchapter III of chapter 83 of this title, chapter 84 of this title, or another retirement system for employees of the Government; or

(iv) on an immediate annuity under a retirement system established for employees described in section 2105(c), in the case of an individual who elected under section 8347(q)(2) or 8461(n)(2) to remain subject to such a system;

(B) a member of a family who receives an immediate annuity as the survivor of an employee (including a family member entitled to an amount under section 8442(b)(1)(A), whether or not such family member is entitled to an annuity under section 8442(b)(1)(B)) or of a retired employee described by subparagraph (A) of this paragraph;

(C) an employee who receives monthly compensation under subchapter I of chapter 81 of this title and who is determined by the Secretary of Labor to be unable to return to duty; and

(D) a member of a family who receives monthly compensation under subchapter I of chapter 81 of this title as the surviving beneficiary of—

(i) an employee who dies as a result of injury or illness compensable under that subchapter; or

(ii) a former employee who is separated after having completed 5 or more years of service and who dies while receiving monthly compensation under that subchapter and who has been held by the Secretary to have been unable to return to duty;

(4) "service", as used by paragraph (3) of this section, means service which is creditable under subchapter III of chapter 83 or chapter 84 of this title;

(5) "member of family" means the spouse of an employee or annuitant and an unmarried dependent child under 22 years of age, including—

(A) an adopted child or recognized natural child; and

(B) a stepchild or foster child but only if the child lives with the employee or annuitant in a regular parent-child relationship;

or such an unmarried dependent child regardless of age who is incapable of self-support because of mental or physical disability which existed before age 22;

(6) "health benefits plan" means a group insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar group arrangement provided by a carrier for the purpose of providing, paying for, or reimbursing expenses for health services;

(7) "carrier" means a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization and an association of organizations or other entities described in this paragraph sponsoring a health benefits plan;

(8) "employee organization" means—

(A) an association or other organization of employees which is national in scope, or in which membership is open to all employees of a Government agency who are eligible to enroll in a health benefits plan under this chapter and which, after December 31, 1978, and before January 1, 1980, applied to the Office for approval of a plan provided under section 8903(3) of this title; and

(B) an association or other organization which is national in scope, in which membership is open only to employees, annuitants, or former spouses, or any combination thereof, and which, during the 90-day period beginning on the date of enactment of section 8903a of this title, applied to the Office for approval of a plan provided under such section;

(9) "dependent", in the case of any child, means that the employee or annuitant involved is either living with or contributing to the support of such child, as determined in accordance with such regulations as the Office shall prescribe;

(10) "former spouse" means a former spouse of an employee, former employee, or annuitant—

(A) who has not remarried before age 55 after the marriage to the employee, former employee, or annuitant was dissolved,

(B) who was enrolled in an approved health benefits plan under this chapter as a family member at any time during the 18-month period before the date of the dissolution of the marriage to the employee, former employee, or annuitant, and

(C)(i) who is receiving any portion of an annuity under section 8345(j) or 8467 of this title or a survivor annuity under section 8341(h) or 8445 of this title (or benefits similar to either of the aforementioned annuity benefits under a retirement system for Government employees other than the Civil Service Retirement System or the Federal Employees' Retirement System),

(ii) as to whom a court order or decree referred to in section 8341(h), 8345(j), 8445, or 8467 of this title (or similar provision of law under any such retirement system other than the Civil Service Retirement System or the Federal Employees' Retirement System) has been issued, or for whom an election has been made under section 8339(j)(3) or 8417(b) of this title (or similar provision of law), or

(iii) who is otherwise entitled to an annuity or any portion of an annuity as a former spouse under a retirement system for Government employees,

except that such term shall not include any such unremarried former spouse of a former employee whose marriage was dissolved after the former em-

ployee's separation from the service (other than by retirement); and

(11) "qualified clinical social worker" means an individual—

(A) who is licensed or certified as a clinical social worker by the State in which such individual practices; or

(B) who, if such State does not provide for the licensing or certification of clinical social workers—

(i) is certified by a national professional organization offering certification of clinical social workers; or

(ii) meets equivalent requirements (as prescribed by the Office).

5 U.S.C. § 8902. Contracting authority

(a) The Office of Personnel Management may contract with qualified carriers offering plans described by section 8903 or 8903a of this title, without regard to section 6101(b) to (d) of title 41 or other statute requiring competitive bidding. Each contract shall be for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of termination by either party.

(b) To be eligible as a carrier for the plan described by section 8903(2) of this title, a company must be licensed to issue group health insurance in all the States and the District of Columbia.

(c) A contract for a plan described by section 8903(1) or (2) of this title shall require the carrier—

(1) to reinsure with other companies which elect to participate, under an equitable formula based on the total amount of their group health insurance benefit payments in the United States during the latest year for which the information is available, to be determined by the carrier and approved by the Office; or

(2) to allocate its rights and obligations under the contract among its affiliates which elect to participate, under an equitable formula to be determined by the carrier and the affiliates and approved by the Office.

(d) Each contract under this chapter shall contain a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as the Office considers necessary or desirable.

(e) The Office may prescribe reasonable minimum standards for health benefits plans described by section 8903 or 8903a of this title and for carriers offering the plans. Approval of a plan may be withdrawn only after notice and opportunity for hearing to the carrier concerned without regard to subchapter II of chapter 5 and chapter 7 of this title. The Office may terminate the contract of a carrier effective at the end of the contract term, if the Office finds that at no time during the preceding two contract terms did the carrier have 300 or more employees and annuitants, exclusive of family members, enrolled in the plan.

(f) A contract may not be made or a plan approved which excludes an individual because of race, sex, health status, or, at the time of the first opportunity to enroll, because of age.

(g) A contract may not be made or a plan approved which does not offer to each employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title whose enrollment in the plan is ended, except by a cancellation of enrollment, a temporary extension of coverage during which he may exercise the option to convert, without evidence of good health, to a nongroup contract providing health benefits. An employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title who exercises this option shall pay the full periodic charges of the nongroup contract.

(h) The benefits and coverage made available under subsection (g) of this section are noncancelable by the carrier except for fraud, over-insurance, or nonpayment of periodic charges.

(i) Rates charged under health benefits plans described by section 8903 or 8903a of this title shall reasonably and equitably reflect the cost of the benefits provided. Rates under health benefits plans described by section 8903(1) and (2) of this title shall be determined on a basis which, in the judgment of the Office, is consistent with the lowest schedule of basic rates generally charged for new group health benefit plans issued to large employers. The rates determined for the first contract term shall be continued for later contract terms, except that they may be readjusted for any later term, based on past experience and benefit adjustments under the later contract. Any readjustment in rates shall be made in advance of the contract term in which they will apply and on a basis which, in the judgment of the Office, is consistent with the general practice of carriers which issue group health benefit plans to large employers.

(j) Each contract under this chapter shall require the carrier to agree to pay for or provide a health service or supply in an individual case if the Office finds that the employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title is entitled thereto under the terms of the contract.

(k)(1) When a contract under this chapter requires payment or reimbursement for services which may be performed by a clinical psychologist, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/clinical specialist, licensed or certified as such under Federal or State law, as applicable, or by a qualified clinical social worker as defined in section 8901(11), an employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title covered by the contract shall be free to select, and shall have direct access to, such a clinical psychologist, qualified clinical social worker, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/nurse clinical specialist without supervision or referral by another health practitioner and shall be entitled under the contract to have payment or reimbursement made to him or on his behalf for the services performed.

(2) Nothing in this subsection shall be considered to preclude a health benefits plan from providing direct access or direct payment or reimbursement to a provider in a health care practice or profession other than a practice or profession listed in paragraph (1), if such provider is licensed or certified as such under Federal or State law.

(3) The provisions of this subsection shall not apply to comprehensive medical plans as described in section 8903(4) of this title.

(*l*) The Office shall contract under this chapter for a plan described in section 8903(4) of this title with any qualified health maintenance carrier which offers such a plan. For the purpose of this subsection, "qualified health maintenance carrier" means any qualified carrier which is a qualified health maintenance organization within the meaning of section 1310(d)(1)[1] of title XIII of the Public Health Service Act (42 U.S.C. 300c-9(d)).

(m)(1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

(2)(A) Notwithstanding the provisions of paragraph (1) of this subsection, if a contract under this chapter provides for the provision of, the payment for, or the reimbursement of the cost of health services for the care and treatment of any particular health condition, the carrier shall provide, pay, or reimburse up to the limits of its contract for any such health service properly provided by any person licensed under State law to provide such service if such service is provided to an individual covered by such contract in a State where 25 percent or more of the population is located in primary medical care manpower shortage areas designated pursuant to section 332 of the Public Health Service Act (42 U.S.C. 254e).

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[1] See References in Text note below.

(B) The provisions of subparagraph (A) shall not apply to contracts entered into providing prepayment plans described in section 8903(4) of this title.

(n) A contract for a plan described by section 8903(1), (2), or (3), or section 8903a, shall require the carrier—

(1) to implement hospitalization-cost-containment measures, such as measures—

(A) for verifying the medical necessity of any proposed treatment or surgery;

(B) for determining the feasibility or appropriateness of providing services on an outpatient rather than on an inpatient basis;

(C) for determining the appropriate length of stay (through concurrent review or otherwise) in cases involving inpatient care; and

(D) involving case management, if the circumstances so warrant; and

(2) to establish incentives to encourage compliance with measures under paragraph (1).

(*o*) A contract may not be made or a plan approved which includes coverage for any benefit, item, or service for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

5 U.S.C. § 8906. Contributions

(a)(1) Not later than October 1 of each year, the Office of Personnel Management shall determine the weighted average of the subscription charges that will be in effect during the following contract year with respect to—

(A) enrollments under this chapter for self alone;

(B) enrollments under this chapter for self plus one; and

(C) enrollments under this chapter for self and family.

(2) In determining each weighted average under paragraph (1), the weight to be given to a particular subscription charge shall, with respect to each plan (and option) to which it is to apply, be commensurate with the number of enrollees enrolled in such plan (and option) as of March 31 of the year in which the determination is being made.

(3) For purposes of paragraph (2), the term "enrollee" means any individual who, during the contract year for which the weighted average is to be used under this section, will be eligible for a Government contribution for health benefits.

(b)(1) Except as provided in paragraphs (2), (3), and (4), the biweekly Government contribution for health benefits for an employee or annuitant enrolled in a health benefits plan under this chapter is adjusted to an amount equal to 72 percent of the weighted average under subsection (a)(1)(A) or (B), as applicable. For an employee, the adjustment begins on the first day of the employee's first pay period of each year. For an annuitant, the adjustment begins on the first day of the first period of each year for which an annuity payment is made.

(2) The biweekly Government contribution for an employee or annuitant enrolled in a plan under this chapter shall not exceed 75 percent of the subscription charge.

(3) In the case of an employee who is occupying a position on a part-time career employment basis (as defined in section 3401(2) of this title), the biweekly Government contribution shall be equal to the percentage which bears the same ratio to the percentage determined under this subsection (without regard to this paragraph) as the average number of hours of such employee's regularly scheduled workweek bears to the average number of hours in the regularly scheduled workweek of an employee serving in a comparable position on a full-time career basis (as determined under regulations prescribed by the Office).

(4) In the case of persons who are enrolled in a health benefits plan as part of the demonstration project under section 1108 of title 10, the Government contribution shall be subject to the limitation set forth in subsection (i) of that section.

(c) There shall be withheld from the pay of each enrolled employee and (except as provided in subsection (i) of this section) the annuity of each enrolled annuitant and there shall be contributed by the Government, amounts, in the same ratio as the contributions of the employee or annuitant and the Government under subsection (b) of this section, which are necessary for the administrative costs and the reserves provided for by section 8909(b) of this title.

(d) The amount necessary to pay the total charge for enrollment, after the Government contribution is deducted, shall be withheld from the pay of each enrolled employee and (except as provided in subsection (i) of this section) from the annuity of each enrolled annuitant. The withholding for an annuitant shall be the same as that for an employee enrolled in the same health benefits plan and level of benefits.

(e)(1)(A) An employee enrolled in a health benefits plan under this chapter who is placed in a leave without pay status may have his coverage and the coverage of members of his family continued under the plan for not to exceed 1 year under regulations prescribed by the Office.

(B) During each pay period in which an enrollment continues under subparagraph (A)—

(i) employee and Government contributions required by this section shall be paid on a current basis; and

(ii) if necessary, the head of the employing agency shall approve advance payment, recoverable in the same manner as under section 5524a(c), of a portion of basic pay sufficient to pay current employee contributions.

(C) Each agency shall establish procedures for accepting direct payments of employee contributions for the purposes of this paragraph.

(2) An employee who enters on approved leave without pay to serve as a full-time officer or employee of an organization composed primarily of employees as defined by section 8901 of this title, within 60 days after entering on that leave without pay, may file with his employing agency an election to continue his health benefits enrollment and arrange to pay currently into the Employees Health Benefits Fund, through his employing agency, both employee and agency contributions from the beginning of leave without pay. The employing agency shall forward the enrollment charges so paid to the Fund. If the employee does not so elect, his enrollment will continue during nonpay status and end as provided by

paragraph (1) of this subsection and implementing regulations.

(3)(A) An employing agency may pay both the employee and Government contributions, and any additional administrative expenses otherwise chargeable to the employee, with respect to health care coverage for an employee described in subparagraph (B) and the family of such employee.

(B) An employee referred to in subparagraph (A) is an employee who—

(i) is enrolled in a health benefits plan under this chapter;

(ii) is a member of a reserve component of the armed forces;

(iii) is called or ordered to active duty in support of a contingency operation (as defined in section 101(a)(13) of title 10);

(iv) is placed on leave without pay or separated from service to perform active duty; and

(v) serves on active duty for a period of more than 30 consecutive days.

(C) Notwithstanding the one-year limitation on coverage described in paragraph (1)(A), payment may be made under this paragraph for a period not to exceed 24 months.

(f) The Government contribution, and any additional payments under subsection (e)(3)(A), for health benefits for an employee shall be paid—

(1) in the case of employees generally, from the appropriation or fund which is used to pay the employee;

(2) in the case of an elected official, from an appropriation or fund available for payment of other salaries of the same office or establishment;

(3) in the case of an employee of the legislative branch who is paid by the Chief Administrative Officer of the House of Representatives, from the applicable accounts of the House of Representatives; and

(4) in the case of an employee in a leave without pay status, from the appropriation or fund which would be used to pay the employee if he were in a pay status.

(g)(1) Except as provided in paragraphs (2) and (3), the Government contributions authorized by this section for health benefits for an annuitant shall be paid from annual appropriations which are authorized to be made for that purpose and which may be made available until expended.

(2)(A) The Government contributions authorized by this section for health benefits for an individual who first becomes an annuitant by reason of retirement from employment with the United States Postal Service on or after July 1, 1971, or for a survivor of such an individual or of an individual who died on or after July 1, 1971, while employed by the United States Postal Service, shall through September 30, 2016, be paid by the United States Postal Service, and thereafter shall be paid first from the Postal Service Retiree Health Benefits Fund up to the amount contained in the Fund, with any remaining amount paid by the United States Postal Service.

(B) In determining any amount for which the Postal Service is liable under this paragraph, the amount of the liability shall be prorated to reflect only that por-

tion of total service which is attributable to civilian service performed (by the former postal employee or by the deceased individual referred to in subparagraph (A), as the case may be) after June 30, 1971, as estimated by the Office of Personnel Management.

(3) The Government contribution for persons enrolled in a health benefits plan as part of the demonstration project under section 1108 of title 10 shall be paid as provided in subsection (i) of that section.

(h) The Office shall provide for conversion of biweekly rates of contribution specified by this section to rates for employees and annuitants paid on other than a biweekly basis, and for this purpose may provide for the adjustment of the converted rate to the nearest cent.

(i) An annuitant whose annuity is insufficient to cover the withholdings required for enrollment in a particular health benefits plan may enroll (or remain enrolled) in such plan, notwithstanding any other provision of this section, if the annuitant elects, under conditions prescribed by regulations of the Office, to pay currently into the Employees Health Benefits Fund, through the retirement system that administers the annuitant's health benefits enrollment, an amount equal to the withholdings that would otherwise be required under this section.

5 U.S.C. § 8907. Information to individuals eligible to enroll

(a) The Office of Personnel Management shall make available to each individual eligible to enroll in a health benefits plan under this chapter such information, in a form acceptable to the Office after con-

sultation with the carrier, as may be necessary to enable the individual to exercise an informed choice among the types of plans described by sections 8903 and 8903a of this title.

(b) Each enrollee in a health benefits plan shall be issued an appropriate document setting forth or summarizing the—

(1) services or benefits, including maximums, limitations, and exclusions, to which the enrollee or the enrollee and any eligible family members are entitled thereunder;

(2) procedure for obtaining benefits; and

(3) principal provisions of the plan affecting the enrollee and any eligible family members.

5 U.S.C. § 8909. Employees Health Benefits Fund

(a) There is in the Treasury of the United States an Employees Health Benefits Fund which is administered by the Office of Personnel Management. The contributions of enrollees and the Government described by section 8906 of this title shall be paid into the Fund. The Fund is available—

(1) without fiscal year limitation for all payments to approved health benefits plans; and

(2) to pay expenses for administering this chapter within the limitations that may be specified annually by Congress.

Payments from the Fund to a plan participating in a letter-of-credit arrangement under this chapter shall, in connection with any payment or reimbursement to

be made by such plan for a health service or supply, be made, to the maximum extent practicable, on a checks-presented basis (as defined under regulations of the Department of the Treasury).

(b) Portions of the contributions made by enrollees and the Government shall be regularly set aside in the Fund as follows:

(1) A percentage, not to exceed 1 percent of all contributions, determined by the Office to be reasonably adequate to pay the administrative expenses made available by subsection (a) of this section.

(2) For each health benefits plan, a percentage, not to exceed 3 percent of the contributions toward the plan, determined by the Office to be reasonably adequate to provide a contingency reserve.

The Office, from time to time and in amounts it considers appropriate, may transfer unused funds for administrative expenses to the contingency reserves of the plans then under contract with the Office. When funds are so transferred, each contingency reserve shall be credited in proportion to the total amount of the subscription charges paid and accrued to the plan for the contract term immediately before the contract term in which the transfer is made. The income derived from dividends, rate adjustments, or other refunds made by a plan shall be credited to its contingency reserve. The contingency reserves may be used to defray increases in future rates, or may be applied to reduce the contributions of enrollees and the Government to, or to increase the benefits provided by, the plan from which the reserves are derived, as the Office from time to time shall determine.

(c) The Secretary of the Treasury may invest and reinvest any of the money in the Fund in interest-bearing obligations of the United States, and may sell these obligations for the purposes of the Fund. The interest on and the proceeds from the sale of these obligations become a part of the Fund.

(d) When the assets, liabilities, and membership of employee organizations sponsoring or underwriting plans approved under section 8903(3) or 8903a of this title are merged, the assets (including contingency reserves) and liabilities of the plans sponsored or underwritten by the merged organizations shall be transferred at the beginning of the contract term next following the date of the merger to the plan sponsored or underwritten by the successor organization. Each employee, annuitant, former spouse, or person having continued coverage under section 8905a of this title affected by a merger shall be transferred to the plan sponsored or underwritten by the successor organization unless he enrolls in another plan under this chapter. If the successor organization is an organization described in section 8901(8)(B) of this title, any employee, annuitant, former spouse, or person having continued coverage under section 8905a of this title so transferred may not remain enrolled in the plan after the end of the contract term in which the merger occurs unless that individual is a full member of such organization (as determined under section 8903a(d) of this title).

(e)(1) Except as provided by subsection (d) of this section, when a plan described by section 8903(3) or (4) or 8903a of this title is discontinued under this chapter, the contingency reserve of that plan shall be credited to the contingency reserves of the plans continuing under this chapter for the contract term fol-

lowing that in which termination occurs, each reserve to be credited in proportion to the amount of the subscription charges paid and accrued to the plan for the year of termination.

(2) Any crediting required under paragraph (1) pursuant to the discontinuation of any plan under this chapter shall be completed by the end of the second contract year beginning after such plan is so discontinued.

(3) The Office shall prescribe regulations in accordance with which this subsection shall be applied in the case of any plan which is discontinued before being credited with the full amount to which it would otherwise be entitled based on the discontinuation of any other plan.

(f)(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any carrier or underwriting or plan administration subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such carrier or underwriting or plan administration subcontractor from business conducted under this chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

(g) The fund described in subsection (a) is available to pay costs that the Office incurs for activities associated with implementation of the demonstration project under section 1108 of title 10.

5 U.S.C. § 8913. Regulations

(a) The Office of Personnel Management may prescribe regulations necessary to carry out this chapter.

(b) The regulations of the Office may prescribe the time at which and the manner and conditions under which an employee is eligible to enroll in an approved health benefits plan described by section 8903 or 8903a of this title. The regulations may exclude an employee on the basis of the nature and type of his employment or conditions pertaining to it, such as short-term appointment, seasonal or intermittent employment, and employment of like nature. The Office may not exclude—

(1) an employee or group of employees solely on the basis of the hazardous nature of employment;

(2) a teacher in the employ of the Board of Education of the District of Columbia, whose pay is fixed by section 1501 of title 31, District of Columbia Code, on the basis of the fact that the teacher is serving under a temporary appointment if the teacher has been so employed by the Board for a period or periods totaling not less than two school years;

(3) an employee who is occupying a position on a part-time career employment basis (as defined in section 3401(2) of this title); or

(4) an employee who is employed on a temporary basis and is eligible under section 8906a(a).

(c) The regulations of the Office shall provide for the beginning and ending dates of coverage of employees, annuitants, members of their families, and former spouses under health benefits plans. The regulations may permit the coverage to continue, exclusive of the temporary extension of coverage described by section 8902(g) of this title, until the end of the pay period in which an employee is separated from the service, or until the end of the month in which an annuitant or former spouse ceases to be entitled to annuity, and in case of the death of an employee or annuitant, may permit a temporary extension of the coverage of members of his family for not to exceed 90 days.

(d) The Secretary of Agriculture shall prescribe regulations to effect the application and operation of this chapter to an individual named by section 8901(1)(H) of this title.

5 U.S.C. § 8959. Preemption

The terms of any contract that relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to dental benefits, insurance, plans, or contracts.

5 U.S.C. § 8989. Preemption

The terms of any contract that relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to vision benefits, insurance, plans, or contracts.

5 U.S.C. § 9005. Preemption

(a) CONTRACTUAL PROVISIONS.—The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to long-term care insurance or contracts.

(b) PREMIUMS.—

(1) IN GENERAL.—No tax, fee, or other monetary payment may be imposed or collected, directly or indirectly, by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, on, or with respect to, any premium paid for an insurance policy under this chapter.

(2) RULE OF CONSTRUCTION.—Paragraph (1) shall not be construed to exempt any company or other entity issuing a policy of insurance under this chapter from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such entity from business conducted under this chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

9 U.S.C. § 2. Validity, irrevocability, and enforcement of agreements to arbitrate

A written provision in any maritime transaction or a contract evidencing a transaction involving commerce to settle by arbitration a controversy thereafter arising out of such contract or transaction, or the refusal to perform the whole or any part thereof, or an agreement in writing to submit to arbitration an existing controversy arising out of such a contract, transaction, or refusal, shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract.

10 U.S.C. § 1103. Contracts for medical and dental care: State and local preemption

(a) OCCURRENCE OF PREEMPTION.—A law or regulation of a State or local government relating to health insurance, prepaid health plans, or other health care delivery or financing methods shall not apply to any contract entered into pursuant to this chapter by the Secretary of Defense or the administering Secretaries to the extent that the Secretary of Defense or the administering Secretaries determine that—

(1) the State or local law or regulation is inconsistent with a specific provision of the contract or a regulation promulgated by the Secretary of Defense or the administering Secretaries pursuant to this chapter; or

(2) the preemption of the State or local law or regulation is necessary to implement or administer the provisions of the contract or to achieve any other important Federal interest.

(b) EFFECT OF PREEMPTION.—In the case of the preemption under subsection (a) of a State or local law or regulation regarding financial solvency, the Secretary of Defense or the administering Secretaries shall require an independent audit of the prime contractor of each contract that is entered into pursuant to this chapter and covered by the preemption. The audit shall be performed by the Defense Contract Audit Agency.

(c) STATE DEFINED.—In this section, the term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, the Commonwealth of the Northern Mariana Islands, and each possession of the United States.

12 U.S.C. § 85. Rate of interest on loans, discounts and purchases

Any association may take, receive, reserve, and charge on any loan or discount made, or upon any notes, bills of exchange, or other evidences of debt, interest at the rate allowed by the laws of the State, Territory, or District where the bank is located, or at a rate of 1 per centum in excess of the discount rate on ninety-day commercial paper in effect at the Federal reserve bank in the Federal reserve district where the bank is located, whichever may be the greater, and no more, except that where by the laws of any State a different rate is limited for banks organized under State laws, the rate so limited shall be allowed for associations organized or existing in any such State under title 62 of the Revised Statutes. When no rate is fixed by the laws of the State, or Territory, or District, the bank may take, receive, reserve, or charge a rate not exceeding 7 per centum,

or 1 per centum in excess of the discount rate on ninety day commercial paper in effect at the Federal reserve bank in the Federal reserve district where the bank is located, whichever may be the greater, and such interest may be taken in advance, reckoning the days for which the note, bill, or other evidence of debt has to run. The maximum amount of interest or discount to be charged at a branch of an association located outside of the States of the United States and the District of Columbia shall be at the rate allowed by the laws of the country, territory, dependency, province, dominion, insular possession, or other political subdivision where the branch is located. And the purchase, discount, or sale of a bona fide bill of exchange, payable at another place than the place of such purchase, discount, or sale, at not more than the current rate of exchange for sight drafts in addition to the interest, shall not be considered as taking or receiving a greater rate of interest.

21 U.S.C. § 360k. State and local requirements respecting devices

(a) General rule

Except as provided in subsection (b) of this section, no State or political subdivision of a State may establish or continue in effect with respect to a device intended for human use any requirement—

(1) which is different from, or in addition to, any requirement applicable under this chapter to the device, and

(2) which relates to the safety or effectiveness of the device or to any other matter included in a re-

quirement applicable to the device under this chapter.

(b) Exempt requirements

Upon application of a State or a political subdivision thereof, the Secretary may, by regulation promulgated after notice and opportunity for an oral hearing, exempt from subsection (a) of this section, under such conditions as may be prescribed in such regulation, a requirement of such State or political subdivision applicable to a device intended for human use if—

(1) the requirement is more stringent than a requirement under this chapter which would be applicable to the device if an exemption were not in effect under this subsection; or

(2) the requirement—

(A) is required by compelling local conditions, and

(B) compliance with the requirement would not cause the device to be in violation of any applicable requirement under this chapter.

29 U.S.C. § 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section

1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(5)(A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393–1 through 393–51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section—

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and section 1136 of this title with officials of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by such parts 1 and 4 and the preceding sections of this part.

(6)(A) Notwithstanding any other provision of this section—

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides—

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to

be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this subchapter, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 1002(1) and section 1003 of this title necessary to be considered an employee welfare benefit plan to which this subchapter applies.

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary

determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

(7) Subsection (a) of this section shall not apply to qualified domestic relations orders (within the meaning of section 1056(d)(3)(B)(i) of this title), qualified medical child support orders (within the meaning of section 1169(a)(2)(A) of this title), and the provisions of law referred to in section 1169(a)(2)(B)(ii) of this title to the extent they apply to qualified medical child support orders.

(8) Subsection (a) of this section shall not be construed to preclude any State cause of action—

(A) with respect to which the State exercises its acquired rights under section 1169(b)(3) of this title with respect to a group health plan (as defined in section 1167(1) of this title), or

(B) for recoupment of payment with respect to items or services pursuant to a State plan for medical assistance approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which would not have been payable if such acquired rights had been executed before payment with respect to such items or services by the group health plan.

(9) For additional provisions relating to group health plans, see section 1191 of this title.

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Co-

lumbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of the United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

(e) Automatic contribution arrangements

(1) Notwithstanding any other provision of this section, this subchapter shall supersede any law of a State which would directly or indirectly prohibit or restrict the inclusion in any plan of an automatic contribution arrangement. The Secretary may prescribe regulations which would establish minimum standards that such an arrangement would be required to satisfy in order for this subsection to apply in the case of such arrangement.

(2) For purposes of this subsection, the term "automatic contribution arrangement" means an arrangement—

(A) under which a participant may elect to have the plan sponsor make payments as contributions under the plan on behalf of the participant, or to the participant directly in cash,

(B) under which a participant is treated as having elected to have the plan sponsor make such contributions in an amount equal to a uniform percentage of compensation provided under the plan until the participant specifically elects not to have such contributions made (or specifically elects to have such contributions made at a different percentage), and

(C) under which such contributions are invested in accordance with regulations prescribed by the Secretary under section 1104(c)(5) of this title.

(3)(A) The plan administrator of an automatic contribution arrangement shall, within a reasonable period before such plan year, provide to each participant to whom the arrangement applies for such plan year notice of the participant's rights and obligations under the arrangement which—

(i) is sufficiently accurate and comprehensive to apprise the participant of such rights and obligations, and

(ii) is written in a manner calculated to be understood by the average participant to whom the arrangement applies.

(B) A notice shall not be treated as meeting the requirements of subparagraph (A) with respect to a participant unless—

(i) the notice includes an explanation of the participant's right under the arrangement not to have elective contributions made on the participant's behalf (or to elect to have such contributions made at a different percentage),

(ii) the participant has a reasonable period of time, after receipt of the notice described in clause (i) and

before the first elective contribution is made, to make such election, and

(iii) the notice explains how contributions made under the arrangement will be invested in the absence of any investment election by the participant.

5 C.F.R. § 890.101. Definitions; time computations *(excerpts)*

* * *

Reimbursement means a carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection withthat illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

* * *

Subrogation means a carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

* * *

5 C.F.R. § 890.106. Carrier entitlement to pursue subrogation and reimbursement recoveries

(a) All health benefit plan contracts shall provide that the Federal Employees Health Benefits (FEHB) carrier is entitled to pursue subrogation and reimbursement recoveries, and shall have a policy to pursue such recoveries in accordance with the terms of this section.

(b)(1) Any FEHB carriers' right to pursue and receive subrogation and reimbursement recoveries constitutes a condition of and a limitation on the nature of benefits or benefit payments and on the provision of benefits under the plan's coverage.

(2) Any health benefits plan contract that contains a subrogation or reimbursement clause shall provide that benefits and benefit payments are extended to a covered individual on the condition that the FEHB carrier may pursue and receive subrogation and reimbursement recoveries pursuant to the contract.

(c) Contracts shall provide that the FEHB carriers' rights to pursue and receive subrogation or reimbursement recoveries arise upon the occurrence of the following:

(1) The covered individual has received benefits or benefit payments as a result of an illness or injury; and

(2) The covered individual has accrued a right of action against a third party for causing that illness or injury; or has received a judgment, settlement or other recovery on the basis of that illness or injury; or is entitled to receive compensation or recovery on the basis of the illness or injury, including from insurers of individual (non-group) policies of liability

insurance that are issued to and in the name of the enrollee or a covered family member.

(d) A FEHB carrier's exercise of its right to pursue and receive subrogation or reimbursement recoveries does not give rise to a claim within the meaning of 5 CFR 890.101 and is therefore not subject to the disputed claims process set forth at 5 CFR 890.105.

(e) Any subrogation or reimbursement recovery on the part of a FEHB carrier shall be effectuated against the recovery first (before any of the rights of any other parties are effectuated) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned.

(f) Pursuant to a subrogation or reimbursement clause, the FEHB carrier may recover directly from any party that may be liable, or from the covered individual, or from any applicable insurance policy, or a workers' compensation program or insurance policy, all amounts available to or received by or on behalf of the covered individual by judgment, settlement, or other recovery, to the extent of the amount of benefits that have been paid or provided by the carrier.

(g) Any contract must contain a provision incorporating the carrier's subrogation and reimbursement rights as a condition of and a limitation on the nature of benefits or benefit payments and on the provision of benefits under the plan's coverage. The corresponding health benefits plan brochure must contain an explanation of the carrier's subrogation and reimbursement policy.

(h) A carrier's rights and responsibilities pertaining to subrogation and reimbursement under any FEHB contract relate to the nature, provision, and extent of

coverage or benefits (including payments with respect to benefits) within the meaning of 5 U.S.C. 8902(m)(1). These rights and responsibilities are therefore effective notwithstanding any state or local law, or any regulation issued thereunder, which relates to health insurance or plans.

48 C.F.R. § 1602.170-2. Community rate

(a) *Community rate* means a rate of payment based on a per member per month capitation rate or its equivalent that applies to a combination of the subscriber groups for a comprehensive medical plan carrier. References in this subchapter to "a combination of cost and price analysis" relating to the applicability of policy and contract clauses refer to comprehensive medical plan carriers using community rates.

(b) *Adjusted community rate* means a community rate which has been adjusted for expected use of medical resources of the FEHBP group. An adjusted community rate is a prospective rate and cannot be retroactively revised to reflect actual experience, utilization, or costs of the FEHBP group, except as described in § 1615.402(c)(4).

48 C.F.R. § 1602.170-7. Experience-rate

Experience-rate means a rate for a given group that is the result of that group's actual paid claims, administrative expenses (including capitated administrative expenses), retentions, and estimated claims incurred but not reported, adjusted for benefit modifications, utilization trends, and economic trends. Actual paid claims include any actual or negotiated

benefits payments made to providers of services for the provision of healthcare such as capitation not adjusted for specific groups, including mental health benefits capitation rates, per diems, and DRG payments.

48 C.F.R. § 1632.170. Recurring premium payments to carriers

(a)(1) *Recurring payments to carriers of community-rated plans.* OPM will pay to carriers of community-rated plans the premium payments received for the plan less the amounts credited to the contingency and administrative reserves, amounts assessed under paragraph (a)(2) of this section, and amounts due for other contractual obligations. Premium payments will be due and payable not later than 30 days after receipt by the Federal Employees Health Benefits (FEHB) Fund.

(2) The difference between one percent and the performance based percentage of the contract price described at 1615.404–4 will be multiplied by the carrier's subscription income for the year of performance and the resulting amount (performance adjustment) will be withheld from the net-to-carrier premium disbursement during the first quarter of the following contract period unless an alternative payment arrangement is made with the carrier's Contracting Officer. Amounts withheld from a community rated plan's premium disbursement will be deposited into the plan's Contingency Reserve.

(3) Any subsidization penalty levied against a community rated plan as outlined in 48 CFR 1615.402(c)(3)(ii)(B) must be paid within 60 days from notification. If payment is not received within

the 60 day period, OPM will withhold from the community rated carriers the periodic premium payment payable until fully recovered. OPM will deposit the withheld funds in the subsidization penalty reserve described in 5 C.F.R. 890.503(c)(6).

(b)(1) *Recurring payments to carriers of experience-rated plans.* OPM will make payments on a letter of credit (LOC) basis. Premium payments received for the plan, less the amounts credited to the contingency and administrative reserves and amounts for other obligations due under the contract, will be made available for carrier drawdown not later than 30 days after receipt by the FEHB Fund.

(2) Withdrawals from the LOC account will be made on a checks-presented basis. Under a checks-presented basis, drawdown on the LOC is delayed until the checks issued for FEHB Program disbursements are presented to the carrier's bank for payment.

(3) OPM may grant a waiver of the restriction of LOC disbursements to a checks-presented basis if the carrier requests the waiver in writing and demonstrates to OPM's satisfaction that the checks-presented basis of LOC disbursements will result in significantly increased liability under the contract, or that the checks-presented basis of LOC disbursements is otherwise clearly and significantly detrimental to the operation of the plan. Payments to carriers that have been granted a waiver may be made by an alternative payment methodology, subject to OPM approval.

APPENDIX H

FEHB Program Carrier Letter

All Carriers

U.S. Office of Personnel Management

Federal Employee Insurance Operations

Letter No. 2012-18

Date: June 18, 2012

Fee-for-service [15] Experience-rated HMO [15] Community-rated HMO [17]

SUBJECT: FEHBA Preemption of State Law re: Subrogation and Reimbursement

The purpose of this letter is to address concerns raised about the ability of Federal Employees Health Benefits (FEHB) Program carriers to collect subrogation and/or reimbursement recoveries. These recoveries occur when an enrollee who is injured obtains benefits from his or her FEHB Program plan and either 1) the plan recovers payment for those benefits from a third party tortfeasor as a subrogee of the enrollee or 2) the enrollee pursues an action against a third party tortfeasor and the terms of the plan require the enrollee, as a result of recovery, to reimburse the plan for benefits initially paid.

Some states are not allowing FEHB Program carriers to collect subrogation and/or reimbursement recoveries due to state law that either prohibits or limits these recoveries. This is to advise you that the Federal Employees Health Benefits Act (FEHBA) preempts state laws prohibiting or limiting subrogation and reimbursement. As a result, FEHB Pro-

gram carriers are entitled to receive these recoveries regardless of state law.

The FEHBA, as codified at 5 U.S.C. § 8902(m)(1) provides:

> The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

FEHB Program contracts and the applicable statement of benefits (brochures) require enrollees to reimburse the plan in the event of a third party recovery. Carriers are required to seek reimbursement and/or subrogation recoveries in accordance with the contract. The funds received by experience-rated carriers from these recoveries are required to be credited to Employees Health Benefits Fund established by 5 U.S.C. § 8909, held by the Treasury of the United States, and for experience-rated carriers and most community-rated carriers, subrogation and reimbursement recoveries serve to lower subscription charges for individuals enrolled in the Federal Employees Health Benefits Program. The carrier's right to subrogation and /or reimbursement recovery is both a condition of, and a limitation on, the payments that enrollees are eligible to receive for benefits; the carrier's contractual obligation to obtain them necessarily relates to the enrollee's coverage or benefits (including payments with respect to benefits) under the FEHB Program. These recoveries therefore fall within the purview of the FEHBA's preemption clause, and supersede state laws that relate to health insurance or health plans.

The United States Supreme Court provided, in *Empire Healthchoice Assurance, Inc. v. McVeigh* that it is plausible to construe subrogation and reimbursement contract terms as a condition or limitation on benefits received by a Federal employee, allowing these FEHB Program contract requirements to preempt state law according to 5 U.S.C. § 8902(m)(1). See, 547 U.S. 677, 697-698 (2006). OPM maintains this construction of the statute allowing for preemption of state laws relating to subrogation and reimbursement.

In support of OPM's position, Federal courts have held that state laws restricting or prohibiting subrogation and/or reimbursement activities "relate" to plans for purposes of triggering the state law preemption provisions of FEHBA. See, e.g.. *Medcenters Health Care v. Ochs*, 26 F.3d 865 (8th Cir. 1994); *NALC Health Benefit Plan v. Lunsford*, 879 F. Supp. 760 (E.D. Mich. 1995); *Botsford v Blue Cross and Blue Shield of Montana, Inc.* 314 F.3d 390 (9th Cir. 2002)(as to conflict preemption).

As the Federal agency with regulatory authority over the FEHB Program, OPM has consistently recognized that the FEHBA preempts state laws that restrict or prohibit FEHB Program carrier reimbursement and/or subrogation recovery efforts, and we continue to maintain this position.

Please utilize this correspondence as needed in your recovery efforts.

Sincerely,

John O'Brien
Director
Healthcare and Insurance

APPENDIX I

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

STANDARD CONTRACT FOR COMMUNITY-RATED HEALTH MAINTENANCE ORGANIZATION CARRIERS

2006

CONTRACT FOR FEDERAL EMPLOYEES HEALTH BENEFITS

CONTRACT NO: CS 1930 AMENDMENT NO: 2006
EFFECTIVE: January 1, 2006 EFFECTIVE: January 1, 2006

BETWEEN: The United States Office of Personnel Management
hereinafter called OPM, the Agency, or the Government

Address: 1900 E Street, NW
Washington, DC 20415-3640

AND

CONTRACTOR: GROUP HEALTH PLAN, INC.
hereinafter called the Carrier

Address: 111 CORPORATE OFFICE DRIVE, SUITE 400
EARTH CITY, MO 63045

In consideration of payment by the Agency of subscription charges set forth in Appendix B, the Carrier agrees to perform all of the services set forth in this contract, including Appendix A.

FOR THE CARRIER	FOR THE GOVERNMENT
Frank D'Antonio	WILLIAM T. STUART
Name of person authorized to execute contract *type or print)*	Name of Contracting Officer *type or print)*
Vice President, Sales & Marketing	CONTRACTING OFFICER
Title	Title
s/	s/
Signature	Signature
11/2/05	November 18, 2005
Date signed	Date signed

* * *

PART I – GENERAL PROVISIONS

* * *

SECTION 1.4
INCORPORATION OF LAWS AND REGULATIONS (JAN 2002)

(a) The applicable provisions of (1) chapter 89 of title 5, United States Code; (2) OPM's regulations as contained in part 890, title 5, Code of Federal Regulations; and (3) chapters 1 and 16 of title 48, Code of Federal Regulations constitute a part of this contract as if fully set forth herein, and the other provisions of this contract shall be construed so as to comply therewith.

(b) If the Regulations are changed in a manner which would increase the Carrier's liability under this contract, the Contracting Officer will make an equitable adjustment in accordance with the changes clause, Section 5.38 – Changes—Negotiated Benefits Contracts.

* * *

SECTION 1.15
RENEWAL AND WITHDRAWAL OF APPROVAL
(JAN 1991) (FEHBAR 1652.249-70)

(a) The contract renews automatically for a term of one (1) year each January first, unless written notice of non-renewal is given either by OPM or the Carrier not less than 60 calendar days before the renewal date, or unless modified by mutual agreement.

(b) This contract also may be terminated at other times by order of OPM pursuant to 5 U.S.C. § 8902(e). After OPM notifies the Carrier of its intent to terminate the contract, OPM may take action as it deems necessary to protect the interests of Members, including but not limited to--

(1) Suspending new enrollments under the contract;

(2) Advising Enrollees of the asserted deficiencies; and

(3) Providing Enrollees an opportunity to transfer to another plan.

(c) OPM may, after proper notice, terminate the contract at the end of the contract term if it finds the Carrier did not have at least 300 Enrollees enrolled in its Plan at any time during the two preceding contract terms.

* * *

PART II – BENEFITS

SECTION 2.1
ENROLLMENT ELIGIBILITY AND EVIDENCE OF ENROLLMENT (JAN 1999)

(a) Enrollment.

(1) Each eligible individual who wishes to be enrolled in the plan offered by this Carrier shall, as a prerequisite to such enrollment, complete a Health Benefits Election Form or use an electronic or telephonic method approved by OPM, within the time and under the conditions specified in 5 CFR Part 890. The Government personnel office having cognizance over the Enrollee shall promptly furnish notification of such election to the Carrier.

(2) A person's eligibility for coverage, effective date of enrollment, the level of benefits (option), the effective date of termination or cancellation of a person's coverage, the date any extension of a person's coverage ceases, and any continuance of benefits beyond a period of enrollment and the date any such continuance ceases, shall all be determined in accordance with regulations or directions of OPM given pursuant to chapter 89, title 5, United States Code.

(b) The Carrier shall, subject to the approval of the Contracting Officer, define an area from which it will accept enrollments. The Carrier may limit enrollment to individuals residing or employed inside the approved area.

(c) The Carrier shall issue evidence of the Enrollee's coverage and furnish to the Enrollee copies of any claim forms as necessary.

SECTION 2.2
BENEFITS PROVIDED (JAN 1999)

(a) The Carrier shall provide the benefits as described in the agreed upon brochure text found in Appendix A.

(1) Benefits offered under this contract may be modified by the Carrier to permit methods of treatment not expressly provided for, but not prohibited by law, rule or Federal policy, if otherwise contractually appropriate, and if such treatment is medically necessary and is as cost effective as providing benefits to which the Member may otherwise be entitled

(2) The Carrier may pay for or provide a health service or supply in an individual case which does not come within the specific benefit provisions of the contract, if the Carrier determines the benefit is within the intent of the contract, and the Carrier determines that the provision of such benefit is in the best interests of the Federal Employees Health Benefits Program.

(3) In individual cases, the Carrier, after consultation with and concurrence by the Member and provider(s), may offer a benefit alternative not ordinarily covered under this contract which will result in equally effective medical treatment at no greater cost. The decision to offer an alternative benefit is solely the Carrier's and is not subject to OPM review under the disputed claims process.

(b) In each case when the Carrier provides a benefit in accordance with the authority of (a)(1), (2) or (3) the Carrier shall document in writing prior to the provision of such benefit the reasons and justification for its determination. Such payment or provision of

services or supplies shall not be considered to be a precedent in the disposition of similar cases.

(c) Except as provided for in (a) above, the Carrier shall provide benefits for services or supplies in accordance with Appendix A.

(d) The Carrier, subject to (e) below, shall determine whether in its judgment a service or supply is medically necessary or payable under this contract.

(e) The Carrier agrees to pay for or provide for a health service or supply in an individual case if OPM finds that the Member is entitled thereto under the terms of the contract.

SECTION 2.3
PAYMENT OF BENEFITS AND PROVISION OF SERVICES AND SUPPLIES (JAN 2003)

(a) By enrolling or accepting services under this contract, Members are obligated to all terms, conditions, and provisions of this contract. The Carrier may request Members to complete reasonable forms or provide information which the Carrier may reasonably request; *provided*, however, that the Carrier shall not require Members to complete any form as a precondition of receiving benefits unless the form has first been approved for use by OPM. Notwithstanding Section 2.11 *Claims Processing*, forms requiring specific approval do not include claim forms and other forms necessary to receive payment of individual claims.

(b) When members are required to file claims for covered benefits, benefits shall be paid (with appropriate documentation of payment) within a reasonable time after receipt of reasonable proof covering the occurrence, character, and extent of the event for which the claim is made. The claimant shall furnish

satisfactory evidence that all services or supplies for which expenses are claimed are covered services or supplies within the meaning of the contract.

(c) The procedures and time period for receiving benefits and filing claims shall be as specified in the agreed upon brochure text (*Appendix A*). However, failure to file a claim within the time required shall not in itself invalidate or reduce any claim where timely filing was prevented by administrative operations of Government or, provided the claim was submitted as soon as reasonably possible.

(d) The Carrier may request a Member to submit to one or more medical examinations to determine whether benefits applied for are for services and supplies necessary for the diagnosis or treatment of an illness or injury or covered condition. The examinations shall be made at the expense of the Carrier.

(e) As a condition precedent to the provision of benefits hereunder, the Carrier, to the extent reasonable and necessary and consistent with Federal law, shall be entitled to obtain from any person, organization or Government agency, including the Office of Personnel Management, all information and records relating to visits or examination of, or treatment rendered or supplies furnished to, a Member as the Carrier requires in the administration of such benefits. The Carrier may obtain from any insurance company or other organization or person any information, with respect to any Member, which it has determined is reasonably necessary to:

(1) identify enrollment in a plan,

(2) verify eligibility for payment of a claim for health benefits, and

(3) carry out the provisions of the contract, such as subrogation, recovery of payments made in error, workers compensation, and coordination of benefits.

(f) When claim filing is required, benefits are payable to the Enrollee in the Plan or his or her assignees. However, under the following circumstances different payment arrangements are allowed:

(1) Reimbursement Payments for the Enrollee. If benefits become payable to the estate of an Enrollee or an Enrollee is a minor, or an Enrollee is physically or mentally not competent to give a valid release, the Carrier may either pay such benefits directly to a hospital or other provider of services or pay such benefits to any relative by blood or connection by marriage of the Enrollee determined by the Carrier to be equitably entitled thereto.

(2) Reimbursement Payments for a minor child. If a child is covered as a family member under the Enrollee's self and family enrollment and is in the custody of a person other than the Enrollee, and if that other person certifies to the Carrier that he or she has custody of and financial responsibility for the dependent child, then the Carrier may issue an identification card for the dependent child(ren) to that person and, when claim filing is required, may reimburse that person for any period covered medical service or supply.

(3) Reimbursement Payments to family members covered under Enrollee's self and family enrollment. If a covered child is legally responsible, or if a covered spouse is legally separated, and if the covered person does not reside with the Enrollee and certifies such conditions to the Carrier, then the Carrier may issue an identification card to the person and when

claim filing is required, the Carrier may reimburse that person for any covered medical service or supply.

(4) Compliance with the HIPAA Privacy Rule. The Carrier may pay benefits to a covered person other than the Enrollee when in the exercise of its discretion the Carrier decides that such action is necessary to comply with the HIPAA Privacy Rule, 45 C.F.R. §164.500 et seq.

(5) Any payments made in good faith in accordance with paragraphs (f)(1) through (f)(4) shall fully discharge the Carrier to the extent of such payment.

(g) *Erroneous Payments.* If the Carrier of OPM determines that a Member's claim has been paid in error for any reason (except fraud and abuse), the Carrier shall make a prompt and diligent effort to recover the erroneous payment to the member from the member or, if to the provider, from the provider. Prompt and diligent effort to recover erroneous payments means that upon discovering that an erroneous payment exists, the Carrier shall—

(1) Send a written notice of erroneous payment to the member or provider that provides: (A) an explanation of when and how the erroneous payment occurred, (B) when applicable, cite the appropriate contractual benefit provision, (C) the exact identifying information (i.e., dollar amount paid erroneously, date paid, check number, date of service and provider name), (D) a request for payment of the debt in full, and (E) an explanation of what may occur should the debt not be paid, including possible offset to future benefits. The notice may also offer an installment option. In addition, the Carrier shall provide the debtor with an opportunity to dispute the existence

and amount of the debt before proceeding with collection activities;

(2) After confirming that the debt does exist and in the appropriate amount, send follow-up notices to the member or the provider at 30, 60 and 90 day intervals, if the debt remains unpaid and undisputed;

(3) The Carrier may off-set future benefits payable to the member or to a provider on behalf of the member to satisfy a debt due under the FEHBP if the debt remains unpaid and undisputed for 120 days after the first notice.

(4) After applying the first three steps, refer cases to a collection attorney or a collection agency if the debt is not recovered;

(5) Make a prompt and diligent effort to recover erroneous payments until the debt is paid in full or determined to be uncollectible by the Carrier because it is no longer cost effective to pursue future collection efforts or it would be against equity and good conscience to continue collection efforts.

(6) Suspend recovery efforts for a debt which is based upon a claim that has been appealed as a disputed claim under Section 2.8, until the appeal has been resolved;

(7) Maintain records that document individual unrecovered erroneous payment collection activities for audit or future reference.

SECTION 2.4
TERMINATION OF COVERAGE AND CONVERSION PRIVILEGES (JAN 1996)

(a) A Member's coverage is terminated as specified in regulations issued by the OPM. Benefits after

termination of coverage are as specified in the regulations.

(b) A Member is entitled to a temporary continuation of coverage or an extension of coverage under the conditions and to the extent specified in the regulations.

(c) A Member whose coverage hereunder has terminated is entitled, upon application within the times and under the conditions specified in regulations, to a non-group contract regularly offered for the purpose of conversion from the contract or similar contracts. The conversion contract shall be in compliance with 5 U.S.C, chapter 89, and regulations issued thereunder.

(d) Costs associated with writing or providing benefits under conversion contracts shall not be an allowable cost of this contract.

(e) The Carrier shall maintain on file with OPM copies of the conversion policies offered to persons whose coverage under this contract terminates and advise OPM promptly of any changes in the policies. The Contracting Officer may waive this requirement where because of the large number of different conversion policies offered by the Carrier it would be impractical to maintain a complete up-to-date file of all policies. In this case the Carrier shall submit a representative sample of the general types of policies offered and provide copies of specific policies on demand.

SECTION 2.5
SUBROGATION (JAN 1998)

(a) The Carrier shall subrogate FEHB claims in the same manner in which it subrogates claims for

non-FEHB members, according to the following rules:

(1) The Carrier shall subrogate FEHB claims if it is doing business in a State in which subrogation is permitted, and in which the Carrier subrogates for non-FEHB members;

(2) The Carrier shall subrogate FEHB claims if it is doing business in a State in which subrogation is prohibited, but in which the Carrier subrogates for at least one plan covered under the Employee Retirement Income Security Act of 1974 (ERISA);

(3) The Carrier shall not subrogate if it is doing business in a State that prohibits subrogation, and in which the Carrier does not subrogate for any plan covered under ERISA;

(4) For Carriers doing business in more than one State, the Carrier shall apply the rules in (1) through (3) of this subsection according to the rule applicable to the State in which the subrogation would take place.

(b) The Carrier's subrogation procedures and policies shall be shown in the agreed upon brochure text or made available to the enrollees upon request.

SECTION 2.6
COORDINATION OF BENEFITS (JAN 2001)
(FEHBAR 1652.204-71)

(a) The Carrier shall coordinate the payment of benefits under this contract with the payment of benefits under Medicare, other group health benefit coverages, and the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault.

(b) The Carrier shall not pay benefits under this contract until it has determined whether it is the primary carrier or unless permitted to do so by the Contracting Officer.

(c) In coordinating benefits between plans, the Carrier shall follow the order of precedence established by the NAIC *Group Coordination of Benefits Model Regulation, Rules for Coordination of Benefits*, as specified by OPM.

(d) Where (1) the Carrier makes payments under this contract which are subject to COB provisions; (2) the payments are erroneous, not in accordance with the terms of the contract, or in excess of the limitations applicable under this contract; and (3) the Carrier is unable to recover such COB overpayments from the Member or the providers of services or supplies, the Contracting Officer may allow such amounts to be charged to the contract; the Carrier must be prepared to demonstrate that it has made a diligent effort to recover such COB overpayments.

(e) COB savings shall be reported by experience-rated carriers each year along with the Carrier's annual accounting statement in a form specified by OPM.

(f) Changes in the order of precedence established by the NAIC *Group Coordination of Benefits Model Regulation, Rules for Coordination of Benefits*, implemented after January 1 of any given year shall be required no earlier than the beginning of the following contract term. *[NOTE: Subsection 2.6(b) will not be applied to this community-rated carrier. When there is double coverage for covered benefits, other than emergency services from non-Plan providers, the Health Maintenance Organization Carrier will con-*

tinue to provide benefits in full, but will seek payment for the services and supplies provided, to the extent that the services and supplies are covered by the other coverage, no-fault automobile insurance or other primary plan. Likewise, Subsection 2.6(d) is not applicable to community-rated carriers.]

SECTION 2.7
DEBARMENT AND OTHER SANCTIONS (JAN 1999)

(a) Notwithstanding 5 U.S.C. 8902(j) or any other provision of the law and regulations, if, under 5 U.S.C. 8902a, 5 CFR 970, or Public Law 103-123 (or other applicable appropriations law), a provider is barred from participating in the Program under 5 U.S.C. or the provider's services under 5 U.S.C. are excluded, the Carrier agrees that no payment shall be made by the Carrier pursuant to any contract under 5 U.S.C. (either to such provider or by reimbursement) for any service or supply furnished by such provider during the period of the debarment, except as provided in 5 CFR 970.200(b).

(b) The OPM shall notify the Carrier when a provider is barred from the FEHBP.

SECTION 2.8
FILING HEALTH BENEFIT CLAIMS/COURT REVIEW OF DISPUTED CLAIMS (MAR 1995) (FEHBAR 1652.204-72)

(a) General. (1) The Carrier resolves claims filed under the Plan. All health benefit claims must be submitted initially to the Carrier. If the Carrier denies a claim, (or a portion of a claim), the covered individual may ask the Carrier to reconsider its denial. If the Carrier affirms its denial or fails to respond as required by paragraph (b) of this clause, the covered

individual may ask OPM to review the claim. A covered individual must exhaust both the Carrier and OPM review processes specified in this clause before seeking judicial review of the denied claim.

(2) This clause applies to covered individuals and to the other individuals or entities who are acting on behalf of a covered individual and who have the covered individual's specific written consent to pursue payment of the disputed claim.

(b) Time limits for reconsidering a claim. (1) The covered individual has 6 months from the date of the notice to the covered individual that a claim (or a portion of a claim) was denied by the Carrier in which to submit a written request for reconsideration to the Carrier. The time limit for requesting reconsideration may be extended when the covered individual shows that he or she was prevented by circumstances beyond his or her control from making the request within the time limit.

(2) The Carrier has 30 days after the date of receipt of a timely-filed request for reconsideration to:

(i) Affirm the denial in writing to the covered individual;

(ii) Pay the phone bill or provide the service; or

(iii) Request from the covered individual or provider additional information needed to make a decision on the claim. The Carrier must simultaneously notify the covered individual of the information requested if it requests additional information from a provider. The Carrier has 30 days after the date the information is received to affirm the denial in writing to the covered individual or pay the bill or provide the service. The Carrier must make its decision based on the evidence it has if the covered individual

or provider does not respond within 60 days after the date of the Carrier's notice requesting additional information. The Carrier must then send written notice to the covered individual of its decision on the claim. The covered individual may request OPM review as provided in paragraph (b)(3) of this clause if the Carrier fails to act within the time limit set forth in this paragraph.

(3) The covered individual may write to OPM and request that OPM review the Carrier's decision if the Carrier either affirms its denial of a claim or fails to respond to a covered individual's written request for reconsideration within the time limit set forth in paragraph (b)(2) of this clause. The covered individual must submit the request for OPM review within the time limit specified in paragraph (e)(1) of this clause.

(4) The Carrier may extend the time limit for a covered individual's submission of additional information to the Carrier when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the additional information.

(c) Information required to process requests for reconsideration. (1) The covered individual must put the request to the Carrier to reconsider a claim in writing and give the reasons, in terms of applicable brochure provisions, that the denied claim should have been approved.

(2) If the Carrier needs additional information from the covered individual to make a decision, it must:

(i) Specifically identify the information needed;

(ii) State the reason the information is required to make a decision on the claim;

(iii) Specify the time limit (60 days after the date of the Carrier's request) for submitting the information; and

(iv) State the consequences of failure to respond within the time limit specified, as set out in paragraph (b)(2) of this section.

(d) Carrier determinations. The Carrier must provide written notice to the covered individual of its determination. If the Carrier affirms the initial request, the notice must inform the covered individual of:

(1) The specific and detailed reasons for the denial;

(2) The covered individual's right to request a review by OPM; and

(3) The requirement that requests for OPM review must be received within 90 days after the date of the Carrier's denial notice and include a copy of the denial notice as well as documents to support the covered individual's position.

(e) OPM review. (1) If the covered individual seeks further review of the denied claim, the covered individual must make a request to OPM to review the Carrier's decision. Such a request to OPM must be made:

(i) Within 90 days after the date of the Carrier's notice to the covered individual that the denial was affirmed; or

(ii) If the Carrier fails to respond to the covered individual as provided in paragraph (b)(2) of this

clause, within 120 days after the date of the covered individual's timely request for reconsideration by the Carrier; or

(iii) Within 120 days after the date the Carrier requests additional information from the covered individual, or the date the covered individual is notified that the Carrier is requesting additional information from a provider. OPM may extend the time limit for a covered individual's request for OPM review when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the request for OPM review within the time limit.

(2) In reviewing a claim denied by the Carrier, OPM may

(i) Request that the covered individual submit additional information;

(ii) Obtain an advisory opinion from an independent physician;

(iii) Obtain any other information as may in its judgment be required to make a determination; or

(iv) Make its decision based solely on the information the covered individual provided with his or her request for review.

(3) When OPM requests information from the Carrier, the Carrier must release the information within 30 days after the date of OPM's written request unless a different time limit is specified by OPM in its request.

(4) Within 90 days after receipt of the request for review, OPM will either:

(i) Give a written notice of its decision to the covered individual and the Carrier; or

(ii) Notify the individual of the status of the review. If OPM does not receive requested evidence within 15 days after expiration of the applicable time limit in paragraph (e)(3) of this clause, OPM may make its decision based solely on information available to it at that time and give a written notice of its decision to the covered individual and to the Carrier.

(f) OPM, upon its own motion, may reopen its review if it receives evidence that was unavailable at the time of its original decision.

(g) Court review. (1) A suit to compel enrollment under § 890.102 of Title 5, Code of Federal Regulation, must be brought against the employing office that made the enrollment decision.

(2) A suit to review the legality of OPM's regulations under this part must be brought against the office of Personnel Management.

(3) Federal Employees Health Benefits (FEHB) carriers resolve FEHB claims under authority of Federal statute (chapter 89, title 5, United States Code). A covered individual may seek judicial review of OPM's final action on the denial of a health benefits claim. A legal action to review final action by OPM involving such denial of health benefits must be brought against OPM and not against the Carrier or the Carrier's subcontractors. The recovery in such a suit shall be limited to a court order directing OPM to require the Carrier to pay the amount of benefits in dispute.

(4) An action under paragraph (3) of this clause to recover a claim for health benefits:

(i) May not be brought prior to exhaustion of the administrative remedies provided in paragraphs (a) through (f) of this clause;

(ii) May not be brought later than December 31 of the 3rd year after the year in which the care or services was provided; and

(iii) Will be limited to the record that was before OPM when it rendered its decision affirming the Carrier's denial of benefits.

SECTION 2.9
PROTECTION OF MEMBERS AGAINST PROVIDER CLAIMS (JAN 1996)

(a) The Carrier shall provide the Contracting Officer with evidence that its contracts with providers (hospitals and physicians) contain a provision that, in the event of Carrier insolvency, or inability to pay expenses for any reason, the providers shall not look to Members for payment. The Carrier agrees that over 90 percent of the total benefit cost under this contract will be provided under such contracts with providers; or

(b) In lieu of subsection (a) above, the Contracting Officer may accept such other combinations of coverage which provide protection of Members against provider claims as defined in the NAIC (National Association of Insurance Commissioners) Model HMO Act, as amended; or

(c) The Carrier shall provide the Contracting Officer with documentation that it has such other appropriate combinations of coverage which would provide protection of Members against provider claims in the event of Carrier insolvency, or inability to pay expenses for any reason.

(d) The Carrier shall notify the Contracting Officer as soon as it is aware that it will not be able to satisfy the requirements stated in subsections (a), (b), or (c) above.

SECTION 2.10
INDEPENDENT LABORATORIES (JAN 1991)

In order to assure a minimum standard of quality for laboratory services, the Carrier agrees that it will not use independent laboratories which do not comply with Medicare or similar standards.

SECTION 2.11
CLAIMS PROCESSING (JAN 2001)

A standardized claims filing process shall be used by all FEHB carriers. The Carrier shall apply procedures for using the standard claims process. At a minimum the Carrier's program must achieve the following objectives:

(1) The majority of provider claims should be submitted electronically;

(2) All providers shall be notified that future claims must be submitted electronically, or on the Centers for Medicare and Medicaid Services 1500 form or the UB-92 form;

(3) The Carrier shall not use any unique provider claim form(s) for FEHB member claims;

(4) The Carrier shall reject all claims submitted on forms other than the CMS 1500 form or the UB-92 form and shall explain the reason on the Explanation of Benefits form; and

(5) The Carrier shall advise OPM of its progress in implementing this policy as directed by the Contracting Officer.

SECTION 2.12
CALCULATION OF COST SHARING PROVISIONS (JAN 1996)

When the Member is required to pay a specified percentage of the cost of covered services, the Member's obligations for covered services shall be based on the amount the provider has agreed to accept as full payment, including future discounts that are known and that can be accurately calculated at the time the claim is processed. This includes for example, prompt pay discounts as well as other discounts granted for various business reasons.

SECTION 2.13
BENEFITS PAYMENTS WHEN MEDICARE IS PRIMARY (JAN 2006)

When a Member who is covered by Medicare Part A, Part B, or Parts A and B on a fee-for-service basis (a) receives services that generally are eligible for a coverage by Medicare (regardless of whether or not benefits are paid by Medicare) and are covered by the Carrier, and (b) Medicare is the primary payer and the Carrier is the secondary payer for the Member under the order of benefit determination rules stated in Appendix A and Appendix D of this contract, then the Carrier shall limit its payment to an amount that supplements the benefits payable by Medicare (regardless of whether or not Medicare benefits are paid). When emergency services have been provided by a Medicare nonparticipating institutional provider and the provider is not reimbursed by Medicare, the Carrier shall pay its primary benefits. Payments that supplement Medicare include amounts necessary to reimburse the Member for Medicare deductibles, coinsurance, copayments, and the balance between the Medicare approved amount

and the Medicare limiting charge made by non-participating providers.

SECTION 2.14
CONTINUING REQUIREMENTS AFTER TERMINATION OF THE CARRIER (JAN 2004)

(a) The Carrier shall fulfill all of the requirements agreed to under the contract that continue after termination. The order of precedence for the applicable laws, regulations, and the contract are listed in Section 1.3.

(b) Contract requirements extend beyond the date of the Carrier's termination until the effective date of the new enrollment including processing and paying claims incurred prior to the effective date of the new enrollment.

(c) When the prior carrier is discontinued in whole or in part, the gaining carrier assumes full coverage on the effective date of the new enrollment.

SECTION 2.15
COORDINATION OF PRESCRIPTION DRUG BENEFITS WITH MEDICARE (JAN 2006)

(a) The Carrier shall comply with the Center for Medicare and Medicaid Services' (CMS) Part D Coordination of Benefits Guidance when the mechanisms and systems indicated in this guidance are in place and functioning properly. This guidance provides the requirements and procedures for coordination of benefits between Part D plans and other providers of prescription drug coverage.

(b) For Medicare Part B covered prescription drugs, the Carrier will coordinate benefits with Medicare except when such prescription drugs are purchased from retail or mail order pharmacies. The

Carrier may pay its benefit on retail pharmacy or mail order drugs eligible for Medicare Part B coverage.

* * *

PART V – REQUIRED CLAUSES

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SECTION 5.50
FEHBP TERMINATION FOR DEFAULT—NEGOTIATED BENEFITS CONTRACTS (JAN 1998) (FEHBAR 1652.249-72)

(a)(1) The Government may, subject to paragraphs (c) and (d) below, by written notice of default to the Carrier, terminate this contract in whole or in part if the Carrier fails to—

(i) Perform the services within the time specified in this contract or any extension;

(ii) Make progress, so as to endanger performance of this contract (but see subparagraph (a)(2) below); or

(iii) Perform any of the other provisions of this contract (but see subparagraph (a)(2) below).

(2) The Government's right to terminate this contract under subdivisions (1)(ii) and (1)(iii) above, may be exercised if the Carrier does not cure such failure within 10 days (or more if authorized in writing by the Contracting Officer) after receipt of the notice from the Contracting Officer specifying the failure.

(b) If the Government terminates this contract in whole or in part, it may acquire, under the terms and in the manner the Contracting Officer considers appropriate, supplies or service similar to those terminated, and the Carrier will be liable to the Govern-

ment for any excess costs for those supplies or services. However, the Carrier shall continue to work not terminated.

(c) Except for defaults of subcontractors at any tier, the Carrier shall not be liable for any excess costs if the failure to perform the contract arises from causes beyond the control and without the fault or negligence of the Carrier. Examples of such causes include (1) acts of God or of the public enemy, (2) acts of the Government in either its sovereign or contractual capacity, (3) fires, (4) floods, (5) epidemics, (6) quarantine restrictions, (7) strikes, (8) freight embargoes, and (9) unusually severe weather. In each instance the failure to perform must be beyond the control and without the fault or negligence of the Carrier.

(d) If the failure to perform is caused by the default of a subcontractor at any tier, and if the cause of the default is beyond the control of both the Carrier and subcontractor, and without the fault or negligence of either, the Carrier shall not be liable for any excess costs for failure to perform, unless the subcontracted supplies or services were obtainable from other sources in sufficient time for the Carrier to meet the required delivery schedule.

(e) If this contract is terminated for default, the Government may require the Carrier to transfer title and deliver to the Government, as directed by the Contracting Officer, any completed or partially completed information and contract rights that the Carrier has specifically produced or acquired for the terminated portion of this contract.

(f) If, after termination, it is determined that the Carrier was not in default, or that the default was

excusable, the rights and obligations of the parties shall be the same as if the termination had been issued for the convenience of the Government.

(g) The rights and remedies of the Government in this clause are in addition to any other rights and remedies provided by law or under this contract.

* * *

SECTION 5.62
APPLICABLE LAW FOR BREACH OF CONTRACT CLAIM (OCT 2004) (FAR 52.233-4)

United States law will apply to resolve any claim of breach of this contract.

* * *

APPENDIX J

Group Health Plan
http://www.ghp.com

GHP **2006**
A Coventry Health Care Plan

A Health Maintenance Organization and a High Deductible Health Plan

Serving: St. Louis/Metro East area, Central Missouri, and Central and Southern Illinois

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 8 for requirements.

* * *

The disputed claims process *(continued)*

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM

decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 800-755-3901 and we will expedite our review; or

b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You may call OPM's Health Insurance Group 3 at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

* * *

When others are responsible for injuries

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

* * *

APPENDIX K

Federal Register / Vol. 80, No. 4 / Wednesday, January 7, 2015 / Proposed Rules

OFFICE OF PERSONNEL MANAGEMENT

5 CFR Part 890

RIN 3206–AN14

Federal Employees Health Benefits Program; Subrogation and Reimbursement Recovery

AGENCY: Office of Personnel Management.

ACTION: Proposed rule.

SUMMARY: The United States Office of Personnel Management (OPM) is issuing a proposed rule to amend the Federal Employees Health Benefits (FEHB) Program regulations to clarify the conditional nature of FEHB Program benefits and benefit payments under the plan's coverage as subject to a carrier's entitlement to subrogation and reimbursement recovery, and therefore, that such entitlement falls within the preemptive scope of the U.S.C. FEHB contracts must include a provision incorporating the carrier's subrogation and reimbursement rights and FEHB plan brochures must explain the carrier's subrogation and reimbursement policy.

DATES: Comments are due on or before February 6, 2015.

ADDRESSES: Send written comments to Marguerite Martel, Senior Policy Analyst, Planning and Policy Analysis, U.S. Office of Personnel Management, Room 4312, 1900 E Street NW., Washington, DC; or

FAX to (202) 606-4640 Attn: Marguerite Martel. You may also submit comments using the *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.

FOR FURTHER INFORMATION CONTACT: Marguerite Martel at *Marguerite.Martel@opm.gov* or (202) 606-0004.

SUPPLEMENTARY INFORMATION: The FEHB Act, as codified at 5 U.S.C. 8902(m)(1) provides: "The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." This proposed regulation reaffirms that a covered individual's entitlement to FEHB benefits and benefit payments is conditioned upon, and limited by, a carrier's entitlement to subrogation and reimbursement recoveries pursuant to a subrogation or reimbursement clause in the FEHB contract. This proposed regulation also reaffirms that a FEHB carrier's rights and responsibilities pertaining to subrogation and reimbursement relate to the nature, provision and extent of coverage or benefits and benefit payments provided under title 5, United States Code Chapter 89, and therefore are effective notwithstanding any state or local law or regulation relating to health insurance or plans. This interpretation comports with longstanding Federal policy, lowers the cost of benefits, and creates greater uniformity in benefits and benefits administration.

Currently, and consistent with longstanding practice, FEHB Program contracts and the applic[illegible]ble statement of benefits (brochures) generally re

quire carriers to seek reimbursement and/or subrogation recoveries, and covered individuals to reimburse the plan in the event of a third party recovery, in accordance with the terms of their FEHB contracts. The funds received by experience-rated carriers from these recoveries are required to be credited to the Employees Health Benefits Fund established by 5 U.S.C. 8909, held by the Treasury of the United States. For experience-rated carriers and most community-rated carriers, subrogation and reimbursement recoveries serve to lower subscription charges for individuals enrolled in the Federal Employees Health Benefits Program. These recoveries occur when an enrollee who is injured obtains benefits from his or her FEHB Program plan and either (1) the carrier recovers payment for those benefits from a third party as a subrogee of the enrollee or (2) the enrollee recovers payment for those benefits from a third party and the terms of the plan require the enrollee, as a result of recovery, to reimburse the carrier for benefits initially paid.

As OPM explained in carrier letter 2012–18 (June 18, 2012), and as this proposed regulation would reaffirm, the carrier's right to subrogation and/or reimbursement recovery is a condition of the payments that enrollees are eligible to receive for benefits, and a limitation on their entitlement to the provision of these benefits. Subrogation and reimbursement clauses in turn relate to the nature, provision, and extent of coverage or benefits (and the payment of benefits) by making those payments conditional upon a right to subrogation or reimbursement of equivalent amounts, either from a third-party, or from the enrollee, in the event a third party is obligated to pay for the same injury or illness. The carrier's right to pursue these recoveries therefore

falls within the purview of 5 U.S.C. 8902(m)(1), and supersedes state laws that relate to health insurance or health plans.

Interpreting subrogation and reimbursement clauses to fall within Section 8902(m)(1) is consistent with the definition of subrogation and reimbursement described above and their relationship to benefits and the payment of benefits. This interpretation also furthers Congress's goals of reducing health care costs and enabling uniform, nationwide application of FEHB contracts. The FEHB program insures approximately 8.2 million federal employees, annuitants, and their families, a significant proportion of whom are covered through nationwide fee-for-service plans with uniform rates. The government pays on average approximately 70% of Federal employees' plan premiums. 5 U.S.C. 8906(b), (f). The government's share of FEHB premiums in 2014 was approximately $33 billion, a figure that tends to increase each year. OPM estimates that FEHB carriers were reimbursed by approximately $126 million in subrogation recoveries in that year. Subrogation recoveries translate to premium cost savings for the federal government and FEHB enrollees. These cost savings are consistent with Congress's intent as expressed in the legislative history of the 1998 amendment to 5 U.S.C. 8902(m)(1), indicating that Congress intended 5 U.S.C. 8902(m)(1) to "prevent carriers' cost-cutting initiatives from being frustrated by State laws," H. Rept. No. 105–374 at 9, 105th Cong., 1st Sess. (1997), and with uniform administration and cost-savings principles first envisioned as major goals of Congress as it initially enacted the FEHBA in 1959. See, H.R. Rep No. 86–957, 86th Cong. 1st Sess. (1959).

In addition to its cost-savings goals, OPM recognizes a strong federal interest in national uniformity in coverage and benefits to include uniform administration of the FEHB program across state lines. This principle encompasses the need to apply uniform rules that affect the rights and obligations of enrollees in a given plan without regard to where they live. Disuniform application of FEHB contract terms as they apply to enrollees in different states is administratively burdensome, gives rise to uncertainty and litigation, and results in treating enrollees differently, although enrolled in the same plan and paying the same premium. It is OPM's understanding that Congress enacted the preemption provision to avoid such disparities, and to enhance the ability of the Federal Government to offer its employees a program of health benefits governed by a uniform set of legal rules.

This proposed rule also clarifies that where a covered individual challenges a carrier's right of subrogation and reimbursement, that challenge is not a "claim," which current OPM regulations define as "a request for payment of a health-related bill" or the "provision of a health-related service or supply." 5 CFR 890.101. Because subrogation and reimbursement challenges are not claims, they are not subject to the disputed claims process set forth at 5 CFR 890.105, 890.107.

The proposed rule adds definitions of subrogation and reimbursement to 5 CFR 890.101. In addition, the regulation replaces the current section 890.106, which is no longer needed due to creation of the Civilian Board of Contract Appeals. The proposed section 890.106 defines an FEHB carrier's right to subrogation and reimbursement in accordance with this

part. As the Federal agency with regulatory authority over the FEHB Program, OPM has consistently taken the position that the FEHB Act preempts state laws that restrict or prohibit FEHB Program carrier reimbursement and/or subrogation recovery efforts, and we continue to maintain this position.

OPM is issuing proposed rule-making that further clarifies this provision of law.

Regulatory Impact Analysis

OPM has examined the impact of this proposed rule as required by Executive Order 12866 and Executive Order 13563, which directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public, health, and safety effects, distributive impacts, and equity). A regulatory impact analysis must be prepared for major rules with economically significant effects of $100 million or more in any one year. This rule is not considered a major rule because there will be a minimal impact on costs to Federal agencies.

Regulatory Flexibility Act

I certify that this regulation will not have a significant economic impact on a substantial number of small entities because the regulation only affects health insurance benefits of Federal employees and annuitants. Executive Order 12866.

Regulatory Review

This rule has been reviewed by the Office of Management and Budget in accordance with Executive Orders 13563 and 12866.

Federalism

We have examined this rule in accordance with Executive Order 13132, Federalism, and have determined that this rule restates existing rights, roles and responsibilities of State, local, or tribal governments.

List of Subjects in 5 CFR Part 890

Administrative practice and procedure, Government employees, Health facilities, Health insurance, Health professions, Hostages, Iraq, Kuwait, Lebanon, Military personnel, Reporting and recordkeeping requirements, Retirement.

U.S. Office of Personnel Management.
Katherine Archuleta,
Director.

Accordingly, OPM proposes to amend title 5, Code of Federal Regulations, part 890 as follows:

PART 890—FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

■ 1. The authority citation for part 890 continues to read as follows:

Authority: 5 U.S.C. 8913; Sec. 890.301 also issued under sec. 311 of Pub. L. 111–03, 123 Stat. 64; Sec. 890.111 also issued under section 1622(b) of Pub. L. 104–106, 110 Stat. 521; Sec. 890.112 also issued under section 1 of Pub. L. 110–279, 122 Stat. 2604; 5 U.S.C. 8913; Sec. 890.803 also issued under 50 U.S.C. 403p, 22 U.S.C. 4069c and 4069c–1; subpart L also issued under sec. 599C of Pub. L. 101–513, 104 Stat. 2064, as amended; Sec. 890.102 also issued under sections 11202(f), 11232(e), 11246 (b) and (c) of Pub. L. 105–33, 111 Stat. 251; and section

721 of Pub. L. 105–261, 112 Stat. 2061; Pub. L. 111–148, as amended by Pub. L. 111–152.

■ 2. In § 890.101(a), add definitions for "Reimbursement" and "Subrogation" in alphabetical order to read as follows:

§ 890.101 Definitions; time computations.

(a) * * *

Reimbursement means a carrier's pursuit of a recovery if a covered individual has been injured and has received a payment from a responsible third party and the terms of the plan require the covered individual, as a result of recovery, to pay the carrier out of the recovery to the extent of the benefits initially paid or provided.

* * * * *

Subrogation means a carrier's pursuit of a recovery from a responsible third party as successor to the rights of an injured covered individual who has obtained benefits from that health benefits plan.

* * * * *

■ 3. Section 890.106 is revised to read as follows:

§ 890.106 Carrier entitlement to pursue subrogation and reimbursement recoveries.

(a) All health benefit plan contracts shall provide that the Federal Employees Health Benefits (FEHB) carrier is entitled to pursue subrogation and reimbursement recoveries, and shall have a policy to pursue such recoveries in accordance with the terms of this section.

(b) In any health benefits plan that contains a subrogation or reimbursement clause, including con-

tracts entered into before the effective date of this regulation, benefits and benefit payments are extended to a covered individual on the condition that the FEHB carrier may pursue and receive subrogation and reimbursement recoveries if such benefits or benefit payments are for an injury or illness that is the responsibility of a third party. FEHB carriers' right to pursue and receive subrogation and reimbursement recoveries constitutes a condition of and a limitation on the nature of benefits or benefit payments and on the provision of benefits under the plan's coverage.

(c) Contracts shall provide that the FEHB carriers' rights to pursue and receive subrogation or reimbursement recoveries arise upon the occurrence of the following:

(1) The covered individual has received benefits or benefit payments as a result of an illness or injury; and

(2) The covered individual has accrued a right of action against a third party for causing that illness or injury; or has received a judgment, settlement or other recovery on the basis of that illness or injury; or is entitled to receive compensation or recovery on the basis of the illness or injury, including from insurers of individual (non-group) policies of liability insurance that are issued to and in the name of the enrollee or a covered family member.

(d) A FEHB carrier's exercise of its right to pursue and receive subrogation or reimbursement recoveries does not give rise to a claim within the meaning of § 890.101 and is therefore not subject to the disputed claims process set forth at § 890.105.

(e) Any subrogation or reimbursement recovery on the part of a FEHB carrier shall be effectuated against the recovery first (before any of the rights of any other parties are effectuated) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned.

(f) Pursuant to a subrogation or reimbursement clause, the FEHB carrier may recover directly from the covered individual all amounts received by or on behalf of the covered individual by judgment, settlement, or other recovery from any third party or its insurer, or the covered individual's insurer, to the extent of the amount of benefits that have been paid or provided by the carrier.

(g) Any contract must contain a provision incorporating the carrier's subrogation and reimbursement rights as a condition of and a limitation on the nature of benefits or benefit payments and on the provision of benefits under the plan's coverage. The corresponding health benefits plan brochure must contain an explanation of the carrier's subrogation and reimbursement policy.

(h) A carrier's rights and responsibilities pertaining to subrogation and reimbursement under a FEHB contract relate to the nature, provision, and extent of coverage or benefits (including payments with respect to benefits) within the meaning of 5 U.S.C. 8902(m)(1). These rights and responsibilities are therefore effective notwithstanding any state or local law, or any regulation issued thereunder, which relates to health insurance or plans.

[FR Doc. 2014–30638 Filed 1–6–15; 8:45 am]

BILLING CODE 6325–63–P

APPENDIX L

Federal Register / Vol. 80, No. 98 / Thursday, May 21, 2015 / Rules and Regulations

OFFICE OF PERSONNEL MANAGEMENT

5 CFR Part 890

RIN 3206–AN14

Federal Employees Health Benefits Program; Subrogation and Reimbursement Recovery

AGENCY: Office of Personnel Management.

ACTION: Final rule.

SUMMARY: The United States Office of Personnel Management (OPM) is issuing a final rule to amend the Federal Employees Health Benefits (FEHB) Program regulations to reaffirm the conditional nature of FEHB Program benefits and benefit payments under the plan's coverage as subject to a carrier's entitlement to subrogation and reimbursement recovery, and therefore, that such entitlement falls within the preemptive scope of the FEHA Act. FEHB contracts and brochures must include, and in practice already include, a provision incorporating the carrier's subrogation and reimbursement rights, and FEHB plan brochures must contain an explanation of the carrier's subrogation and reimbursement policy.

DATES: This final rule is effective June 22, 2015.

FOR FURTHER INFORMATION CONTACT: Marguerite Martel, Senior Policy Analyst at (202) 606-0004.

SUPPLEMENTARY INFORMATION: The FEHB Act, as codified at 5 U.S.C. 8902(m)(1), provides:

"The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." This final regulation reaffirms that a covered individual's entitlement to FEHB benefits and benefit payments is conditioned upon, and limited by, a carrier's entitlement to subrogation and reimbursement recoveries pursuant to a subrogation or reimbursement clause in the FEHB contract. This final regulation also reaffirms that a FEHB carrier's rights and responsibilities pertaining to subrogation and reimbursement relate to the nature, provision and extent of coverage or benefits and benefit payments provided under title 5, United States Code Chapter 89, and therefore are effective notwithstanding any state or local law or regulation relating to health insurance or plans. Some state courts have interpreted ambiguity in Section 8902(m)(1) to reach a contrary result and thereby to allow state laws to prevent or limit subrogation or reimbursement rights under FEHB contracts. In this final rule, OPM is exercising its rulemaking authority under 5 U.S.C. 8913 to ensure that carriers enjoy the full subrogation and reimbursement rights provided for under their contracts.

The interpretation of Section 8902(m)(1) promulgated herein comports with longstanding Federal policy and furthers Congress's goals of reducing health care costs and enabling uniform, nationwide application of FEHB contracts. The FEHB program insures approximately 8.2 million federal employees, annuitants, and their families, a significant proportion of whom are covered through nationwide fee-for-service plans with uniform rates. The government

pays on average approximately 70% of Federal employees' plan premiums. 5 U.S.C. 8906(b), (f). The government's share of FEHB premiums in 2014 was approximately $33 billion, a figure that tends to increase each year. OPM estimates that FEHB carriers were reimbursed by approximately $126 million in subrogation recoveries in that year. Subrogation recoveries translate to premium cost savings for the federal government and FEHB enrollees.

OPM proposed this amendment in a notice of proposed rulemaking on January 7, 2015 (80 FR 931). The proposed rule had a 30 day comment period during which OPM received 3 comments.

Responses to comments on the proposed rule:

OPM received comments from an association of FEHB carriers, a trade association serving subrogation and recovery professionals, and a provider of subrogation and recovery services. The comments all expressed support for the regulation and suggested some changes to clarify the language in the proposed rule.

All commenters suggested edits to the proposed definitions of "subrogation" and "reimbursement" at 5 CFR 890.101 to more completely reflect the universe of FEHB Program plan recoveries. All three commenters expressed concern with the reference to "a responsible third party" in the definitions, indicating that the use of this phrase has been interpreted to foreclose "first party" claims for subrogation and recoveries, such as uninsured and underinsured motorist coverage, and recommended adding other insurance including workers' compensation insurance, to the definition to be consistent with entitlements listed in the proposed § 890.106(c)(2) and (f). OPM

agrees that the definitions of subrogation and reimbursement should include first party claims. In addition, commenters noted that § 890.106(b) and (f) should be updated to reflect this change. The definitions at § 890.101 and other corresponding sections have been updated accordingly as necessary.

The commenters also suggested additional specific changes to the proposed definition of "reimbursement." Two of the commenters noted that the definition of reimbursement should address the situation of both illness and injury. OPM has revised the definition of reimbursement to accept this change. One commenter suggested that the final rule clarify that the right of reimbursement is cumulative with and not exclusive of the right of subrogation. OPM has incorporated this clarification. Two commenters suggested that the definition should reflect that a covered individual need not have actually received a recovery payment so long as the covered individual is entitled to receive a payment. OPM does not agree that the right of reimbursement is sufficiently broad to require an individual to reimburse the carrier in a circumstance where the individual has not actually received a recovery, and rejects this change. One commenter indicated that the right of reimbursement is specific to a recovery from an individual who has received a third party payment while the right of subrogation permits a carrier to recover directly from other sources. OPM agrees with this comment and has clarified the definition of "subrogation" accordingly.

One commenter suggested that § 890.106(b) be amended to align the regulation and FEHB carrier contract requirements. OPM has revised this section to refer to contractual requirements.

One commenter noted that § 890.106(f) should be clarified to ensure that the carrier has a subrogation right to recover directly from a responsible insurer all amounts available to or on behalf of the covered individual. We have clarified the provision accordingly.

Two commenters noted that proposed § 890.106(b) and (h) did not clearly reflect OPM's intention for this regulation to apply to existing contracts. We agree and are slightly revising the language of paragraphs (b) and (h) to be clearer. Paragraph (h) formalizes OPM's longstanding interpretation of what Section 8902(m)(1) has meant since Congress enacted it in 1978. This interpretation applies to all FEHBA contracts. Paragraph (b)(1) in the final rule likewise formalizes OPM's longstanding interpretation of subrogation and reimbursement clauses in carrier contracts as constituting a condition of and a limitation on the nature of benefits or benefits payments and on the provision of benefit payments. See Carrier Letter 2012–18. FEHBA contracts that contain subrogation and reimbursement clauses condition benefits and benefit payments on giving the carrier a right to pursue subrogation and reimbursement and therefore are directly related to benefits, benefit payments, and coverage within the meaning of Section 8902(m)(1). The interpretations in paragraphs (b)(1) and (h) together clarify and ensure that carriers enjoy full subrogation and reimbursement rights notwithstanding any state law to the contrary, and they apply in any pending or future case.

To clarify further the relationship among subrogation, reimbursement, benefits, and coverage, we are also in paragraph (b)(2) requiring carrier con-

tracts that contain subrogation and reimbursement clauses to contain language specifying that benefits and benefit payments are extended to a covered individual on the condition that the carrier may pursue and receive subrogation and reimbursement. This substantive requirement, unlike the interpretation discussed above, will govern any benefit payment made under any carrier contract entered into after this regulation goes into effect.

OPM is issuing this final rule with changes to §§ 890.101(a) and 890.106(b) and (f) as described above.

Regulatory Flexibility Act

I certify that this regulation will not have a significant economic impact on a substantial number of small entities because the regulation because the regulation only affects health insurance benefits of Federal employees and annuitants. Executive Order 12866.

Regulatory Review

This rule has been reviewed by the Office of Management and Budget in accordance with Executive Orders 13563 and 12866.

Federalism

We have examined this rule in accordance with Executive Order 13132, Federalism, and have determined that this rule restates existing rights, roles and responsibilities of State, local, or tribal governments.

List of Subjects in 5 CFR Parts 890

Administrative practice and procedure, Government employees, Health facilities, Health insurance,

Health professions, Hostages, Iraq, Kuwait, Lebanon, Military personnel, Reporting and recordkeeping requirements, Retirement.

U.S. Office of Personnel Management.
Katherine Archuleta,
Director.

PART 890—FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

■ 1. The authority citation for part 890 continues to read as follows:

Authority: 5 U.S.C. 8913. Sec. 890.301 also issued under sec. 311 of Pub. L. 111–03, 123 Stat. 64; Sec. 890.111 also issued under section 1622(b) of Pub. L. 104–106, 110 Stat. 521; Sec. 890.112 also issued under section 1 of Pub. L. 110–279, 122 Stat. 2604; 5 U.S.C. 8913; Sec. 890.803 also issued under 50 U.S.C. 403p, 22 U.S.C. 4069c and 4069c–1; subpart L also issued under sec. 599C of Pub. L. 101–513, 104 Stat. 2064, as amended; Sec. 890.102 also issued under sections 11202(f), 11232(e), 11246 (b) and (c) of Pub. L. 105–33, 111 Stat. 251; and section 721 of Pub. L. 105–261, 112 Stat. 2061.

■ 2. In § 890.101, in paragraph (a), add definitions in alphabetical order for "reimbursement" and "subrogation" to read as follows:

§ 890.101 Definitions; time computations.

(a) * * *

Reimbursement means a carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and

the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

* * * * *

Subrogation means a carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

* * * * *

■ 3. Section 890.106 is revised to read as follows:

§ 890.106 Carrier entitlement to pursue subrogation and reimbursement recoveries.

(a) All health benefit plan contracts shall provide that the Federal Employees Health Benefits (FEHB) carrier is entitled to pursue subrogation and reimbursement recoveries, and shall have a policy to pursue such recoveries in accordance with the terms of this section.

(b)(1) Any FEHB carriers' right to pursue and receive subrogation and reimbursement recoveries constitutes a condition of and a limitation on the nature of benefits or benefit payments and on the provision of benefits under the plan's coverage.

(2) Any health benefits plan contract that contains a subrogation or reimbursement clause shall provide that benefits and benefit payments are extended to a covered individual on the condition that

the FEHB carrier may pursue and receive subrogation and reimbursement recoveries pursuant to the contract.

(c) Contracts shall provide that the FEHB carriers' rights to pursue and receive subrogation or reimbursement recoveries arise upon the occurrence of the following:

(1) The covered individual has received benefits or benefit payments as a result of an illness or injury; and

(2) The covered individual has accrued a right of action against a third party for causing that illness or injury; or has received a judgment, settlement or other recovery on the basis of that illness or injury; or is entitled to receive compensation or recovery on the basis of the illness or injury, including from insurers of individual (non-group) policies of liability insurance that are issued to and in the name of the enrollee or a covered family member.

(d) A FEHB carrier's exercise of its right to pursue and receive subrogation or reimbursement recoveries does not give rise to a claim within the meaning of 5 CFR 890.101 and is therefore not subject to the disputed claims process set forth at 5 CFR 890.105.

(e) Any subrogation or reimbursement recovery on the part of a FEHB carrier shall be effectuated against the recovery first (before any of the rights of any other parties are effectuated) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned.

(f) Pursuant to a subrogation or reimbursement clause, the FEHB carrier may recover directly from any party that may be liable, or from the covered individual, or from any applicable insurance policy, or

a workers' compensation program or insurance policy, all amounts available to or received by or on behalf of the covered individual by judgment, settlement, or other recovery, to the extent of the amount of benefits that have been paid or provided by the carrier.

(g) Any contract must contain a provision incorporating the carrier's subrogation and reimbursement rights as a condition of and a limitation on the nature of benefits or benefit payments and on the provision of benefits under the plan's coverage. The corresponding health benefits plan brochure must contain an explanation of the carrier's subrogation and reimbursement policy.

(h) A carrier's rights and responsibilities pertaining to subrogation and reimbursement under any FEHB contract relate to the nature, provision, and extent of coverage or benefits (including payments with respect to benefits) within the meaning of 5 U.S.C. 8902(m)(1). These rights and responsibilities are therefore effective notwithstanding any state or local law, or any regulation issued thereunder, which relates to health insurance or plans.

[FR Doc. 2015–12378 Filed 5–20–15; 8:45 am]

BILLING CODE 6325–63–P

APPENDIX M

IN THE SUPREME COURT OF MISSOURI
No. SC93134

JODIE NEVILS,
Appellant,

v.

GROUP HEALTH PLAN, INC et al.
Respondents.

TRANSFER FROM THE MISSOURI COURT OF APPEALS EASTERN DISTRICT

AMICUS CURIAE BRIEF OF THE UNITED STATES IN SUPPORT OF RESPONDENTS

* * *

STATEMENT OF INTEREST

The United States respectfully submits this *amicus curiae* brief.

This case presents the question whether Missouri's anti-subrogation rule is preempted by the Federal Employee Health Benefits Act (FEHBA), which provides that "[t]he terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." 5 U.S.C. § 8902(m)(1). The United States has a strong interest in the correct resolution of this issue, which concerns the health-insurance benefits that the federal government provides to federal employees pursuant to federal law.

STATEMENT

A. Statutory Background

1. Congress enacted the Federal Employees Health Benefits Act of 1959, Pub. L. No. 86-382, 73 Stat. 708, to establish a comprehensive program that would "assure maximum health benefits for [federal] employees at the lowest possible cost to themselves and to the Government." H.R. Rep. No. 86-957, at 4 (1959). Through FEHB plans, the federal government provides health insurance to millions of federal employees and their dependents.

The U.S. Office of Personnel Management administers the Federal Employees Health Benefits Act. The Act gives OPM authority to contract with insurance carriers to offer benefits to federal employees, annuitants, and dependents, 5 U.S.C. §§ 8902, 8903, 8903b, to seek civil penalties against FEHB insurance carriers who engage in misconduct in administering federal health plans, *id.* § 8902a(d), and to promulgate regulations implementing FEHBA, *id.* § 8913(a). Each contract must contain "a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as the Office considers necessary or desirable." *Id.* § 8902(d).

Federal employees have the option to enroll in FEHB plans under the terms of the contracts between OPM and insurance carriers. 5 U.S.C. § 8905(a). OPM must provide to federal employees the information necessary to make an informed choice among the various plans offered under FEHB, and OPM issues each enrolled employee a detailed statement setting forth the plan terms and proce-

dures for obtaining benefits under the plan. *Id.* § 8907.

The federal government shares responsibility with enrolled employees for paying the premiums under FEHB plans. 5 U.S.C. § 8906. The federal government pays on average approximately 70% of the employee's plan premium. *Id.* § 8906(b), (f). FEHB premiums are generally deposited into the Employee Health Benefits Fund in the U.S. Treasury. *Id.* § 8909(a).

Most FEHB program contracts provide for a right of subrogation. A right of subrogation requires, among other things, FEHB beneficiaries to reimburse the plan if the beneficiary recovers a tort judgment or settlement that compensated the insured, in whole or in part, for health-insurance benefits the plan paid. Carriers must seek reimbursement in accordance with the FEHB contract. The funds received from subrogation recoveries by experienced-rated carriers, such as fee-for-service carriers, are credited to the Employee Health Benefits Fund held by the Treasury. *See* 5 U.S.C. § 8909(a). Any surplus in the FEHB fund may be used, based on negotiations between OPM and the carrier, to reduce future government and employee contributions, increase plan benefits, or refund money to the government and plan enrollees. 5 U.S.C. § 8909(b); 5 C.F.R. § 890.503(c)(2). Subrogation recoveries credited to the FEHB fund thus translate to direct savings for the federal government and FEHB enrollees.

FEHB carriers also include community-rated carriers. Subrogation recoveries by community-rated carriers also lower subscription charges for enrollees and the federal government, but through a different

mechanism. The premiums that community-rated carriers charge generally depend on the expected cost of providing benefits. Subrogation recoveries by community-rated carriers tend to reduce those expected costs, and thus the premiums.

OPM has the ultimate authority to determine whether a claim for medical services should be paid under the FEHB program. 5 U.S.C. § 8902(j). If a carrier denies payment for a claim, the covered employee may seek OPM review. 5 C.F.R. § 890.105(a)(1). OPM's determination is subject to judicial review in federal court under the Administrative Procedure Act. 5 U.S.C. §§ 701, 706.

2. In the mid-1970s, Congress became concerned that various forms of state health insurance legislation affecting FEHB health insurance plans were resulting in "[i]ncreased premium costs to both the Government and enrollees," as well as "[a] lack of uniformity of benfits [sic] for enrollees in the same plan which would result in enrollees in some States paying a premium based, in part, on the cost of benefits provided only to enrollees in other States." H.R. Rep. No. 94-1211, at 3 (1976). Many states had begun enacting laws "requiring not only specific types of care but the extent of benefits, family members to be covered, the age limits for family members, extension of coverage, the format and the type of informational material that must be furnished, including in some instances the type of language to be used ...." H.R. Rep. No. 95-282, at 6-7 (1977); *see* S. Rep. No. 95-903, at 7 (1978). Congress cured the emerging disuniformity by enacting a preemption provision providing that "[t]he provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with re-

spect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions." Act of Sept. 17, 1978, Pub. L. No. 95-368, 92 Stat. 606.

In 1998, Congress broadened the FEHBA preemption provision. *See* Federal Employees Health Care Protection Act of 1998, Pub. L. No. 105-266, § 3(c), 112 Stat. 2363, 2366. Congress, in particular, preempted not only laws regulating the nature and extent of benefits, but also those regulating the provision of coverage or benefits—such as laws that regulate nationwide managed-care organizations. *See* H.R. Rep. No. 105-374, at 9, 16 (1997). Congress also eliminated as a prerequisite to preemption that a state law be "inconsistent" with a FEHB contract, "thereby giving the federal contract provisions clear authority." S. Rep. No. 105-257, at 15 (1997). Congress did so to "to strengthen the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live," and to "prevent carriers' cost-cutting initiatives from being frustrated by State laws." H.R. Rep. No. 105-374, at 9 (1997).

As amended, the FEHBA's preemption provision provides that "[t]he terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." 5 U.S.C. § 8902(m)(1).

B. Factual Background

This case arises from an FEHB contract entered into between OPM and Group Health Plan Inc., a community-rated health plan. Section 2.5 of that contract provided that the carrier "shall subrogate FEHB claims in the same manner in which it subrogates claims for non-FEHB members" under certain conditions, including where the carrier "is doing business in a State in which subrogation is prohibited, but in which the Carrier subrogates for at least one plan covered under the Employee Retirement Income Security Act of 1974." Legal File (LF) 57. Although Missouri law generally prohibits insurance subrogation, *see, e.g.*, *Schweiss* v. *Sisters of Mercy, St. Louis, Inc.*, 950 S.W.2d 537, 538 (Mo. Ct. App. 1997), GHP subrogates FEHB claims in Missouri because it subrogates for at least one ERISA plan in Missouri, *see* LF 218.

Plaintiff Jodie Nevils is a former federal employee who was covered by a GHP-administered FEHB health-insurance plan while he was with the government. LF 292-93. In November 2006, plaintiff sustained injuries in a car crash. LF 292. The FEHB plan paid approximately $18,000 in benefits to defray plaintiff's medical bills. LF 293, 571. Plaintiff brought a tort suit against the driver and settled the case. LF 293. Pursuant to the FEHB plan's subrogation clause, GHP's agent, ACS Recovery Services Inc., asserted a lien against the settlement proceeds. LF 293, 573. ACS, GHP, and plaintiff settled the lien for $6,592.24. LF 575.

Plaintiff then brought this class-action suit in St. Louis County Circuit Court. The suit asserted multiple state-law causes of action against GHP, all of which were premised on the assertion that the ac-

tions of GHP and ACS in collecting $6,592.24 from plaintiff's tort settlement violated Missouri's anti-subrogation law. LF 294-300. Plaintiff sought unspecified damages and injunctive relief. LF 300.

GHP and ACS sought summary judgment, principally on the ground that the Federal Employees Health Benefits Act preempts Missouri's anti-subrogation law. LF 8-12, 349-62. The trial court agreed, explaining that the case was controlled by *Buatte* v. *Gencare Health Sys., Inc.*, 939 S.W.2d 440 (Mo. Ct. App. 1996), LF 864-65, which held that "Missouri state law prohibiting subrogation is preempted by the FEHBA." *Id.* at 442. The trial court found no basis for plaintiff's argument that more recent court decisions had deprived *Buatte* of its precedential effect, and no reason not to follow that controlling precedent. LF 865. The court therefore granted GHP and ACS summary judgment on all claims. *Id.*

The Missouri Court of Appeals affirmed, agreeing with the trial court that *Buatte* was controlling. 2012 WL 6689542, at *3 (Mo. Ct. App. Dec. 26, 2012). The court of appeals rejected plaintiff's arguments that *Buatte* should be reconsidered in light of subsequent legal developments. *Id.* at *3-*5. Plaintiff argued, specifically, that the Supreme Court's decision in *Empire Healthchoice Assurance* v. *McVeigh*, 547 U.S. 677 (2006), which also involved subrogation rights under a FEHB contract, controlled the preemption question presented here. The court of appeals explained, however, that "[t]he *Empire* court's holding was solely that federal question jurisdiction was lacking" over an action to enforce an insurance company's right to reimbursement for benefits paid under a FEHB contract. *Id.* at *5. The

court of appeals observed that this holding was "not even tangentially related" to the separate question of whether the FEHBA preempts Missouri's anti-subrogation rule. *Id.*

This Court granted plaintiff's motion to transfer.

POINTS RELIED ON

Response To Appellant's Point I: The Court Of Appeals Correctly Concluded That The Federal Employee Health Benefits Act Preempts Missouri's Anti-Subrogation Rule.

5 U.S.C. § 8902(m)(1)

FEHB Program Carrier Letter No. 2012-18 (June 18, 2012)

Buatte v. *Gencare Health Sys., Inc.*, 939 S.W.2d 440 (Mo. Ct. App. 1996)

MedCenters Health Care v. *Ochs*, 26 F.3d 865 (8th Cir. 1994)

NALC Health Benefit Plan v. *Lunsford*, 879 F. Supp. 760 (E.D. Mich. 1995)

ARGUMENT

The Federal Employee Health Benefits Act Preempts Missouri's Anti-Subrogation Rule.

A. Section § 8902(m)(1) Unambiguously Preempts Missouri's Anti-Subrogation Rule.

Like most health-insurance contracts, FEHB contracts generally provide for a right of subrogation. A subrogation right, among other things, permits the FEHB plan to receive reimbursement for any benefits paid under the plan to the extent that the enrollee has separately received a tort recovery that also

compensates for the very same expenses paid by the plan. Subrogation rights, in other words, prevent enrollees from receiving double reimbursement for their medical expenses. The vast majority of state jurisdictions permit subrogation if provided for by the express terms of a health insurance contract. Missouri, however, is in the minority of jurisdictions that do not permit subrogation, even when a health-insurance contract provides for it. *See* Johnny C. Parker, *The Made Whole Doctrine: Unraveling the Enigma Wrapped in the Mystery of Insurance Subrogation*, 70 Mo. L. Rev. 723, 734-35 & n.56 (2005).

1. The question in this case is whether the FEHBA preempts Missouri's anti-subrogation rule. The FEHBA provides that "[t]he terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." 5 U.S.C. § 8902(m)(1).

The sweeping terms of this express preemption provision comfortably encompass anti-subrogation laws. FEHB contract terms that provide a right of subrogation directly "relate to the ... extent of coverage or benefits" or, at the very least, "payments with respect to benefits." 5 U.S.C. § 8902(m)(1). Subrogation rights relate to benefit payments because they require a beneficiary to return benefits to the extent the beneficiary has been separately reimbursed for those benefits from a tort recovery. As the Missouri Court of Appeals observed in holding that the FEHBA preempts Missouri's anti-subrogation rule, "prohibiting" the carrier "from seeking reimbursement from its insured would clearly differ the extent

of coverage or benefits." *Buatte* v. *Gencare Health Sys., Inc.*, 939 S.W.2d 440, 442 (Mo. Ct. App. 1996); *accord MedCenters Health Care* v. *Ochs*, 26 F.3d 865, 867 (8th Cir. 1994) (holding Minnesota anti-subrogation law preempted by § 8902(m)(1)); *NALC Health Benefit Plan* v. *Lunsford*, 879 F. Supp. 760, 762-63 (E.D. Mich. 1995) (holding that § 8902(m)(1) preempted Michigan law to the extent Michigan law prohibited subrogation).

In this case, there is no dispute that the subrogation right in Section 2.5 of the GHP contract establishes that plaintiff is not entitled to FEHB benefits to the extent that plaintiff's medical bills were separately reimbursed out of a tort recovery or settlement. If plaintiff's state-law suit based on Missouri's anti-subrogation rule succeeds in defeating that right, plaintiff will have been permitted to retain FEHB benefits that he is not entitled to keep under the terms of the FEHB contract. Missouri's anti-subrogation rule straightforwardly relates to the extent of coverage or benefits under an FEHB plan and is therefore preempted.

2. The conclusion that Missouri's anti-subrogation rule relates to benefits and coverage, as well as payments with respect to benefits, draws support from Supreme Court cases construing the term "relat[es] to" in a preemption provision to "express a broad pre-emptive purpose." *Morales* v. *TWA*, 504 U.S. 374, 383 (1992). The Supreme Court has, with regard to the similarly worded preemption clause applicable to health-care plans regulated by the Employee Retirement Income Security Act of 1974, held that state anti-subrogation laws "relate to" such plans. *See FMC Corp.* v. *Holliday*, 498 U.S. 52, 58-59 (1990); *see also Botsford* v. *Blue Cross* &

Blue Shield of Montana, Inc., 314 F.3d 390, 394 (9th Cir. 2002) (applying ERISA case law to interpreting 5 U.S.C. § 8902(m)(1)). In reaching that conclusion, the Supreme Court observed that anti-subrogation laws are related to the provision of benefits in that they "require[] plan providers to calculate benefit levels ... based on expected liability conditions that differ from those in States that have not enacted similar antisubrogation legislation," thus "frustrat[ing] plan administrators' continuing obligation to calculate uniform benefit levels nationwide." *FMC Corp.*, 498 U.S. at 60. ERISA regulates the benefit plans that private employers offer their employees, while the FEHBA governs the health-benefit plans that the federal government provides. It is exceedingly unlikely that Congress intended a broader role for state law in the case of federal employees than in the case of private employees, or that Congress desired less uniformity in the case of federal employees.

3. The history and purpose of the FEHBA preemption provision confirms that Congress intended it to supersede state anti-subrogation law.

In the mid-1970s, states began undermining the uniformity of the FEHB program by mandating that insurance companies provide health-insurance benefits that were not covered under the terms of FEHB contracts. *See, e.g.*, H.R. Rep. No. 95-282, at 6 (1977). Congress became concerned that those laws resulted in FEHB enrollees in some states paying for benefits that they were not receiving, since some benefits were only provided in states that had mandated-benefit laws. *See* H.R. Rep. No. 94-1211, at 3 (1976). Congress also expressed concern that state mandated-benefit laws were increasing the cost of the FEHB program to the federal government, *see*

id., which pays the lion's share of FEHB premiums. In response to those developments, Congress broadly preempted state laws related to benefits or coverage that were inconsistent with FEHB contract terms, and later broadened preemption to supersede even state laws that were not expressly inconsistent with FEHB contracts. *See* Pub. L. No. 95-368, 92 Stat. 606 (1978); Pub. L. No. 105-266, § 3(c), 112 Stat. 2363, 2366 (1998).

Missouri's anti-subrogation rule is indistinguishable from the state mandated-benefit laws that Congress expressly targeted with the enactment of the FEHBA preemption provision. By permitting an FEHB enrollee to retain benefits that have been separately reimbursed by a tort recovery, Missouri law effectively requires FEHB providers to provide Missouri consumers with FEHB benefits that consumers in other states do not receive under the terms of the same FEHB contract. Most FEHB enrollees receive benefits under nationwide plans with uniform rates. If Missouri's anti-subrogation rule survives preemption, then, the loser will be FEHB enrollees in states that permit subrogation, who will be subsidizing the more generous benefits that Missouri law effectively mandates that FEHB carriers provide to Missouri residents. That kind of cross-subsidization creates precisely the disuniformity that Congress intended to preclude when it enacted the preemption provision, which it intended to "strengthen the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live." H.R. Rep. No. 105-374, at 9 (1997).

Missouri's anti-subrogation rule also runs contrary to another key aim of Congress in providing for preemption, which was to "prevent carriers' cost-

cutting initiatives from being frustrated by State laws." H.R. Rep. No. 105-374, at 9 (1997). Although not all FEHB contracts necessarily provide for a right of subrogation, the vast majority do. Any subrogation recoveries obtained by the carrier tend to reduce the premiums charged both to individuals enrolled in the FEHB program and to the federal government, which pays the bulk of FEHB premiums. The federal government's share of those premiums amounted to approximately $31.5 billion in 2012 alone.

Even if plaintiff were correct that subrogation does not relate to benefits within the meaning of § 8902(m)(1), then, Missouri's law would still be in conflict with the FEHBA because it would "stand[] as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Arizona* v. *United States*, 132 S. Ct. 2492, 2505 (2012) (internal quotation marks and citation omitted); *see id.* at 2501.

B. The Supreme Court's Decision In *McVeigh* Did Not Hold Otherwise.

In contending that state laws prohibiting subrogation survive the FEHBA's preemption provision, plaintiff makes virtually no attempt to grapple with the statute's language, purpose, or history. Instead, plaintiff spends the bulk of his brief arguing that the Supreme Court in *Empire Healthchoice Assurance, Inc.* v. *McVeigh*, 547 U.S. 677 (2006), has already decided the preemption question presented in this case in his favor. Pl. Br. 12-19. That contention is without merit.

1. The question presented in *McVeigh* was whether there is federal jurisdiction over a suit

brought by a FEHB health-insurance carrier to recover reimbursement that a beneficiary allegedly owed the FEHB program under an FEHB contract. 547 U.S. at 683. The Supreme Court held that there is no federal-question jurisdiction over such a suit, emphasizing that "Congress has not expressly created a federal right of action enabling insurance carriers ... to sue health-care beneficiaries in federal court to enforce reimbursement rights under contracts contemplated by FEHBA." *Id.* at 693.

In the course of resolving the jurisdictional issue, the Court explored the meaning of the preemption provision. "Reading the reimbursement clause" in the FEHB contract "as a condition or limitation on 'benefits' received by a federal employee," the Court explained, "the clause could be ranked among '[contract] terms ... relat[ing] to ... coverage or benefits' and 'payments with respect to benefits,' thus falling within § 8902(m)(1)'s compass." *Id.* at 697 (alterations the Supreme Court's). "On the other hand," the Court continued, "a claim for reimbursement ordinarily arises long after 'coverage' and 'benefits' questions have been resolved, and corresponding 'payments with respect to benefits' have been made to care providers or the insured." *Ibid.* "With that consideration in view, § 8902(m)(1)'s words may be read to refer to contract terms relating to the *beneficiary's* entitlement (or lack thereof) to Plan payment for certain health-care services he or she has received, and not to terms relating to the carrier's postpayments right to reimbursement." *Ibid.* (Court's emphasis). The Court, however, explained that it "need not choose between those plausible constructions" of the preemption clause "[t]o decide this case." *Id.* at 698.

Contrary to plaintiff's contention, the Supreme Court in *McVeigh* did not decide, and in fact expressly declined to decide, that state laws affecting a FEHB carrier's right to reimbursement do not relate to coverage or benefits under § 8902(m)(1). Although the Court did at one point "distinguish[] ... between benefits and reimbursement," *Blue Cross Blue Shield* v. *Cruz*, 495 F.3d 510, 513 (7th Cir. 2007), the Court also found it "plausible" to construe a carrier's right to reimbursement for benefits as directly relating to benefits, or at least "payments with respect to benefits." *McVeigh*, 547 U.S. at 698; *see id.* at 697; *see also Cruz*, 495 F.3d at 514 (deciding that federal jurisdiction did not exist over a carrier's reimbursement suit, but declining to decide whether state law was preempted under § 8902(m)(1)).

Plaintiff contends, based on the presumption against preemption of state law, that the Supreme Court's ambivalence about which of these interpretations is correct compels the conclusion that only one of them is correct—*viz.*, the interpretation disfavoring preemption. Pl. Br. 18-19. That argument is irreconcilable with the Supreme Court's conclusion that it is "plausible" to conclude that the FEHBA preempts state anti-subrogation laws, *McVeigh*, 547 U.S. at 698, which the Court would not have done if, as plaintiff asserts, the presumption against preemption made that interpretation implausible and impermissible. *McVeigh* therefore in no way diminishes the conclusion that the broad, sweeping language of the FEHBA preemption provision encompasses state anti-subrogation laws.

2. In any event, the Supreme Court's tentative attempt in *McVeigh*—in at best nonbinding *dictum*—to distinguish "benefits" from "reimbursement" is

simply untenable, particularly in the context of anti-subrogation laws such as the one before the Court in this case. Even putting to one side the evident oddity of viewing a right to reimbursement of benefits as being unrelated to benefits, a right of subrogation is not limited to "reimbursement," and may indeed directly concern "the *beneficiary's* entitlement (or lack thereof) to Plan payment for certain health-care services he or she has received." *McVeigh*, 547 U.S. at 697 (emphasis the Supreme Court's). If a beneficiary, for example, received a tort judgment that compensates for medical bills covered under the plan before receiving FEHB benefits from the carrier, a subrogation right would permit the carrier to deny the enrollee benefits before the plan ever paid them. Denying benefit payments clearly "relates to benefits." But the only difference between that scenario and the facts of this case is that here, the carrier paid plaintiff FEHB benefits before he obtained his tort settlement (or at least before the carrier or its recovery agent was aware of it). That distinction should make no difference: a subrogation right does not become unrelated to benefits simply because the benefits happen to have already been paid, and the carrier must seek reimbursement of improperly retained benefits after the fact from a tort judgment or settlement. Plaintiff's submission, by contrast, rests on the implausible presumption that Congress intended preemption of subrogation laws to depend on the timing of a tort judgment or settlement.

3. Since the Supreme Court decided *McVeigh*, the U.S. Office of Personnel Management, the agency Congress entrusted with administering the FEHBA, *see Dyer* v. *Blue Cross & Blue Shield Ass'n, Inc.*, 848 F.2d 201, 205 (D.C. Cir. 1988); *Blue Cross & Blue Shield* v. *Dep't of Banking & Finance*, 791 F.2d

1501, 1506 (11th Cir. 1986), has in an opinion letter construed 5 U.S.C. § 8902(m)(1) to preempt state anti-subrogation laws, adopting the interpretation of the preemption provision that the Supreme Court explicitly characterized as plausible in *McVeigh*. *See* FEHB Program Carrier Letter No. 2012-18 (June 18, 2012), Add. A1. OPM's letter confirms that a right of subrogation "is both a condition of, and a limitation on, the payments that enrollees are eligible to receive for benefits," and therefore preempts state laws that defeat subrogation rights. *Ibid.* OPM's letter also explains the strong federal interest in preemption of state anti-subrogation laws, which tend to increase the expense of the FEHB program. *Ibid.*

Although OPM's opinion letter lacks the force of law that typically accompanies a regulation promulgated after notice-and-comment rulemaking, OPM's authoritative construction of the FEHBA is nonetheless entitled to substantial weight.[1] *See Christensen* v. *Harris County*, 529 U.S. 576, 587 (2000) (citing *Skidmore* v. *Swift & Co.*, 323 U.S. 134, 140 (1944)); *see also Dyer*, 848 F.2d at 205; *Blue Cross & Blue Shield*, 791 F.2d at 1506 (OPM's construction of § 8902(m)(1) entitled to deference as long as it is "reasonable"). OPM's plausible interpretation should be granted deference, *see Nat'l Cable & Telecomms. Ass'n* v. *Brand X Internet Servs.*, 545 U.S. 967, 980-82 (2005), and confirms that Missouri's anti-subrogation rule is preempted.

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[1] Plaintiff's substitute brief asserts that OPM's opinion letter is "factually inaccurate and misleading" in stating that "Carriers are required to seek reimbursement and/or subrogation in accordance with the contract." Pl. Br. 23 (internal quotation marks omitted). But that statement is accurate because OPM's point is simply that, if an FEHB contract requires subrogation, the carrier should seek subrogation as the contract provides.

CONCLUSION

The judgment of the trial court should be affirmed.

* * *

MAY 2013

* * *

APPENDIX N

IN THE SUPREME COURT OF MISSOURI

JODIE NEVILS,	)	
	)	
Appellant,	)	
	)	
v.	)	Case No. SC93134
	)	
GROUP HEALTH PLAN, INC. ET AL.,	)	
	)	
	)	
Respondents	)	

UNOPPOSED MOTION OF THE UNITED STATES FOR LEAVE TO PARTICIPATE IN ORAL ARGUMENT

The Court has scheduled oral argument in this case for September 12, 2013. The United States respectfully requests leave to participate in the oral argument. Respondents' counsel have agreed to the United States' participation in argument and to cede 5 of their 15 minutes of argument time to the United States. Plaintiff does not oppose this motion.

The United States filed an *amicus curiae* brief in this case, which presents the question whether Missouri's anti-subrogation rule is preempted by the Federal Employee Health Benefits Act (FEHBA). The preemption provision states that "[t]he terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any

regulation issued thereunder, which relates to health insurance or plans." 5 U.S.C. § 8902(m)(1).

The United States has a strong interest in the correct resolution of this issue, which concerns the health insurance benefits that the federal government provides to federal employees pursuant to federal law. The U.S. Office of Personnel Management is the agency Congress has entrusted with authority to administer the FEHBA. Courts have deferred to OPM's interpretation of the FEHBA, *see Dyer* v. *Blue Cross & Blue Shield Ass'n, Inc.*, 848 F.2d 201, 205 (D.C. Cir. 1988); *Blue Cross & Blue Shield* v. *Dep't of Banking & Finance*, 791 F.2d 1501, 1506 (11th Cir. 1986), and OPM respectfully submits that this Court would benefit from OPM's views on the proper scope of preemption. Under FEHBA, moreover, OPM contracts with insurance carriers to provide health insurance to federal employees, and the federal government is responsible for the lion's share of the premiums, paying approximately $31.5 billion in premiums on behalf of federal enrollees in 2012 alone. The federal government has a substantial interest in ensuring that FEHB insurance carriers may pursue subrogation recoveries, which tend to reduce the premiums the federal government and FEHBA enrollees pay under the FEHB program on a nationwide basis.

Henry C. Whitaker, an attorney with the Appellate Staff of the Civil Division of the U.S. Department of Justice, was the attorney principally responsible for preparing the *amicus* brief filed by the United States and would be the attorney assigned to present oral argument if the Court grants this motion. If the Court grants this motion, we would separately

submit a motion for Mr. Whitaker to be admitted to this Court's bar *pro hac vice*.

As noted, respondents' counsel have agreed to cede 5 of their 15 minutes of their oral argument time to the United States, and to the United States' participation in the argument. We have also consulted with counsel for plaintiff, and plaintiff does not oppose this motion.

* * *

Dated: July 22, 2013

APPENDIX O

IN THE SUPREME COURT OF MISSOURI

No. SC93134

JODIE NEVILS,
Appellant,

v.

COVENTRY HEALTH CARE OF MISSOURI, INC.
formerly known as Group Health Plan, Inc.,
Respondent.

On Remand from the Supreme Court
of the United States
No. 13-1305

Appeal from the Circuit Court of St. Louis County
No. 11SL-CC00535
Hon. Thea A. Sherry, Circuit Judge
(Transfer from No. ED98538)

AMICUS CURIAE BRIEF OF THE UNITED STATES IN SUPPORT OF RESPONDENT

* * *

INTRODUCTION

The United States respectfully submits this *amicus curiae* brief in support of respondent.

Under the Federal Employee Health Benefits Act (FEHBA), the federal government contracts with insurance carriers to provide health insurance to federal employees and their families, and pays tens of billions of dollars of the program's premiums. If a

FEHB contract term "relates[]" to "benefits" or "payments with respect to benefits," FEHBA preempts any state law that "relates to health insurance or plans." 5 U.S.C. § 8902(m)(1). The question here is whether this statute preempts state laws that prevent FEHB carriers from enforcing contractual rights of subrogation and reimbursement.

This Court previously concluded that this statute does not preempt Missouri's anti-subrogation law. *See Nevils* v. *Group Health Plan, Inc.*, 418 S.W.3d 451, 460 (Mo. 2014) (Appellant's App. 6). The U.S. Supreme Court granted certiorari, vacated this Court's decision, and remanded for consideration of the issue in light of a new regulation issued by the Office of Personnel Management (OPM), which is the federal agency responsible for administering the FEHB program. *See* 135 S. Ct. 2886 (2015). The new OPM regulation concluded that subrogation and reimbursement provisions in FEHB contracts relate to benefits and benefit payments, and therefore under the statute are effective notwithstanding contrary state law. *See* 80 Fed. Reg. 29,203 (May 21, 2015) (Appellant's App. 17).

OPM's regulation is, as both this Court and the U.S. Supreme Court have recognized, a "plausible," *Nevils*, 418 S.W.3d at 545; *Empire Healthchoice Assurance, Inc.* v. *McVeigh*, 547 U.S. 677, 698 (2006), and hence reasonable, interpretation of the statute. The Tenth Circuit recently upheld the same OPM regulation that is at issue here. *See Helfrich* v. *Blue Cross & Blue Shield Ass'n*, __ F. 3d __, No. 14-3179, slip op. (10th Cir. Oct. 29, 2015). Accordingly, FEHBA preempts Missouri's anti-subrogation law, and the judgment of the court of appeals should be affirmed.

POINT RELIED ON

POINT 1: FEHBA Preempts Missouri's Anti-Subrogation Law.

Helfrich v. *Blue Cross & Blue Shield Ass'n*, __ F. 3d __, No. 14-3179, slip op. (10th Cir. Oct. 29, 2015)

City of Arlington v. *FCC*, 133 S. Ct. 1863, 1874 (2013)

Empire HealthChoice Assurance, Inc. v. *McVeigh*, 547 U.S. 677 (2006)

Smiley v. *Citibank (South Dakota), N.A.*, 517 U.S. 735 (1996)

OPM Final Rule, 80 Fed. Reg. 29,203 (May 21, 2005) (Appellant's App. 17)

5 C.F.R. § 890.106

ARGUMENT

POINT 1: FEHBA Preempts Missouri's Anti-Subrogation Law.

A. The Federal Employee Health Benefits Act provides: "The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." 5 U.S.C. § 8902(m)(1).

In *Empire HealthChoice Assurance, Inc.* v. *McVeigh*, 547 U.S. 677 (2006), the Supreme Court left open the question whether the terms in FEHB contracts providing for subrogation and reimbursement "relate to the ... extent of coverage or benefits"

or "payments with respect to benefits," 5 U.S.C. § 8902(m)(1), and thus preempt state anti-subrogation and reimbursement laws. On the one hand, the Supreme Court observed that "[r]eading the reimbursement clause" in a FEHB contract "as a condition or limitation on 'benefits' received by a federal employee," "the clause could be ranked among '[contract] terms ... relat[ing] to ... coverage or benefits' and 'payments with respect to benefits,' thus falling within § 8902(m)(1)'s compass." *McVeigh*, 547 U.S. at 697. "On the other hand," the Court continued, "a claim for reimbursement ordinarily arises long after 'coverage' and 'benefits' questions have been resolved, and corresponding 'payments with respect to benefits' have been made to care providers or the insured." *Id.* "With that consideration in view, § 8902(m)(1)'s words may be read to refer to contract terms relating to the beneficiary's entitlement (or lack thereof) to Plan payment for certain health-care services he or she has received, and not to terms relating to the carrier's postpayments right to reimbursement." *Id.* (emphasis omitted). The Court concluded that it "need not choose between those plausible constructions" of the preemption clause "[t]o decide this case." *Id.* at 698.

OPM recently resolved through notice-and-comment rulemaking the question left open by *McVeigh*. The OPM regulation provides that "[a]ny FEHB carriers' right to pursue and receive subrogation and reimbursement recoveries constitutes a condition of and a limitation on the nature of benefits or benefit payments and on the provision of benefits under the plan's coverage." 5 C.F.R. § 890.106(b)(1). Thus, "[a] carrier's rights and responsibilities pertaining to subrogation and reimbursement under any FEHB contract relate to the nature, provision, and

extent of coverage or benefits (including payments with respect to benefits) within the meaning of 5 U.S.C. 8902(m)(1)." *Id.* § 890.106(h). "These rights and responsibilities are therefore effective notwithstanding any state or local law, or any regulation issued thereunder, which relates to health insurance or plans." *Id.*[19]

The OPM regulation is a reasonable interpretation of the statute that Congress charged OPM with administering through rulemaking, *see* 5 U.S.C. § 8913(a), and the regulation is therefore controlling here, *see City of Arlington* v. *FCC,* 133 S. Ct. 1863, 1874 (2013). As this Court observed in its prior decision, *Nevils*, 418 S.W.3d at 454-55, the Supreme Court in *McVeigh* expressly acknowledged that it is "plausible" to regard FEHB contract terms providing for subrogation and reimbursement "as a condition or limitation on 'benefits' received by a federal employee." 547 U.S. at 697. It therefore left OPM free to interpret the statute to preempt state anti-subrogation and reimbursement laws. *See National Cable & Telecomms. Ass'n* v. *Brand X Internet Servs.*, 545 U.S. 967, 982 (2005). And as OPM explained, its interpretation "comports with longstanding Federal policy and furthers Congress's goals of reducing health care costs and enabling uniform, nationwide application of FEHB contracts." 80 Fed. Reg. at 29,203 (Appellant's App. 17). "The FEHB program insures approximately 8.2 million federal employees, annuitants, and their families, a significant propor-

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[19] OPM also created a prospective requirement that all FEHB contracts shall explicitly provide that benefits and benefit payments are conditioned on FEHB carriers' exercise of subrogation and reimbursement rights. *See* 80 Fed. Reg. at 29,204 (discussing 5 C.F.R. § 890.106(b)(2)) (Appellant's App. 18).

tion of whom are covered through nationwide fee-for-service plans with uniform rates." *Id.* "The government pays on average approximately 70% of Federal employees' plan premiums." *Id.* (citing 5 U.S.C. § 8906(b), (f)). "The government's share of FEHB premiums in 2014 was approximately $33 billion, a figure that tends to increase each year." *Id.* OPM estimated that "FEHB carriers were reimbursed by approximately $126 million in subrogation recoveries in that year." *Id.* Accordingly, "[s]ubrogation recoveries translate to premium cost savings for the federal government and FEHB enrollees." *Id.*

The Tenth Circuit recently upheld the validity of this regulation in *Helfrich* v. *Blue Cross & Blue Shield Ass'n*, __ F. 3d __, No. 14-3179, slip op. (10th Cir. Oct. 29, 2015). The court recognized that a right to reimbursement of FEHB benefits is "tied directly to 'payments with respect to benefits'" within the meaning of 5 U.S.C. § 8902(m)(1). *Helfrich*, slip op. at 31. The court correctly explained that "a carrier's contractual right to reimbursement and subrogation arises from its payment of benefits; and an enrollee's ultimate entitlement to benefit payments is conditioned upon providing reimbursement from any later recovery or permitting the Plan to recover on the enrollee's behalf." *Id.*

The court also concluded that OPM's regulation "strongly buttress[ed]" that conclusion. *Helfrich*, slip op. at 34. The court observed that OPM's views were entitled to weight because "[a]s the agency that has negotiated FEHBA contracts for federal employees for years, OPM has deep knowledge of the impact and interrelationships of contractual provisions." *Id.* at 38. "Its longstanding and persuasively explained view that subrogation and reimbursement provisions

are directly tied to employee health benefits and advance the congressional purposes served by § 8902(m)(1)," the court continued, "is, in our view, of sufficient weight to persuade us to agree with its conclusion regarding preemption." *Id.* at 38-39.[20]

B. Plaintiff provides no persuasive reason to disregard the OPM regulation and create a conflict with the Tenth Circuit.

1. Plaintiff argues that OPM's regulation is not entitled to deference under *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council*, 467 U.S. 837 (1984), because OPM is interpreting the scope of an express preemption clause. Pl. Br. 39-44. The Tenth Circuit in *Helfrich* found it unnecessary to decide whether the OPM regulation was entitled to full *Chevron* deference, because it correctly upheld the validity of the agency's regulation even under the more demanding, less deferential standard of *Skidmore* v. *Swift*, 323 U.S. 134 (1944). *See Helfrich*, slip

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[20] Despite never advancing this argument at any stage in the prior Missouri court proceedings, plaintiff now contends that the contract contains no right to "reimbursement" because it only mentions "subrogation." Pl. Br. 20-25. The contract in this case provides that the carrier "shall subrogate FEHB claims in the same manner in which it subrogates claims for non-FEHB members." Pl. Br. 9 n.2. It is OPM's understanding that, under this clause of the contract, the carrier was permitted to pursue both subrogation and reimbursement recoveries for FEHB members. While "subrogation" and "reimbursement" are indeed "separate legal and contractual rights," Pl. Br. 22 (citing OPM regulations), it is also true that the term "subrogation" is often in FEHB contracts used in a generic sense to encompass both a right of subrogation and a right of reimbursement, and that is the sense evidently meant here. *See New Orleans Assets, LLC* v. *Woodward*, 363 F.3d 372, 377 (5th Cir. 2004); *McVeigh*, 547 U.S. at 692 & n.4 (repeatedly observing that rights of subrogation and reimbursement are "linked").

op. at 37-38. Likewise, this Court may uphold the regulation without reaching the question of *Chevron* deference.

If this Court reaches the issue, *Chevron* deference is appropriate. As this Court previously explained, *Chevron* deference is "typically applied 'where an agency rule sets forth important rights and duties, where the agency focuses fully and directly on the issue, where the agency uses notice-and-comment procedures to promulgate a rule, [and] where the resulting rule falls within the statutory grant of authority." *Nevils*, 418 S.W.3d at 457 n.2 (quoting *Long Island Care at Home Ltd.* v. *Coke*, 551 U.S. 158, 173 (2007)). All of that is true of the regulation in question here. The Supreme Court has repeatedly applied the *Chevron* framework to an agency's construction of the preemptive scope of the statutes it administers, including express preemption clauses. *See Cuomo* v. *Clearing House Ass'n*, 557 U.S. 519, 525 (2009); *New York* v. *FERC*, 535 U.S. 1, 28 (2002); *Medtronic, Inc.* v. *Lohr*, 518 U.S. 470, 496 (1996).

In *Smiley* v. *Citibank (South Dakota), N.A.*, 517 U.S. 735 (1996), for example, the Supreme Court was faced with the question whether a regulation of the Comptroller of the Currency interpreting Section 30 of the National Bank Act was valid. Section 30 was a preemption provision providing that a national bank may charge interest at the rate allowed by the laws of the State where the bank is located. *See id.* at 737. The Comptroller's regulation interpreted this provision to supersede state laws that prohibit a national bank from charging late-payment fees that are lawful in the bank's home state. *See id.* at 740. The Supreme Court deferred to the agency's interpreta-

tion and held that this regulation was entitled to *Chevron* deference because it was a "full-dress regulation, issued by the Comptroller himself and adopted pursuant to the notice-and-comment procedures of the Administrative Procedure Act." *Id.* at 741.

Even more recently, in *City of Arlington*, the Supreme Court rejected the contention that the applicability of *Chevron* deference depends on a provision-by-provision analysis of the statute an agency is charged with administering. 133 S. Ct. at 1868-73. The Court held that "the whole includes all of its parts," and rejected the claim that "a general conferral of rulemaking authority does not validate rules for *all* the matters the agency is charged with administering." *Id.* at 1874. The Court noted, for example, that it had "deferred to the FCC's assertion that its broad regulatory authority extends to pre-empting conflicting state rules." *Id.* at 1871. Here, the matters OPM is charged with administering likewise include FEHBA's preemption clause. *See* 5 U.S.C. §§ 8913(a), 8902(m)(1).

Nor is it surprising that Congress delegated OPM such authority. The statute provides for the preemption of state laws relating to health insurance or FEHB plans, where those state laws conflict with FEHB contract terms that relate to benefits or benefit payments. *See* 5 U.S.C. § 8902(m)(1). Congress, in turn, expressly delegated OPM authority to negotiate and interpret those contract terms in providing health benefits for the federal government's own employees. *See id.* § 8902(a); 5 C.F.R. § 890.105(a)(1). The preemption question here thus implicates issues at the core of OPM's specialized expertise over administration of the FEHB program. Deference to agency preemption determinations is especially ap-

propriate when the "agency is likely to have a thorough understanding of its own regulation and its objectives and is uniquely qualified to comprehend the likely impact of state requirements." *Geier* v. *American Honda Motor Co.*, 529 U.S. 861, 883 (2000) (internal quotation marks omitted).

FEHBA's legislative history confirms the point. As plaintiff repeatedly notes, OPM's predecessor entity, the Civil Service Commission, had expressed doubt, before the enactment of FEHBA's preemption clause in 1978, whether the Commission had statutory authority to issue a regulation regarding FEHBA preemption. Pl. Br. 39, 42 (citing Report of the Comptroller General of the U.S.: *Conflicts Between State Health Insurance Requirements and Contracts of the Federal Employee Health Benefits Carriers* at 15 (Oct. 15 1975) (Appellant's App. 62)). What plaintiff does not note is that this doubt led the Civil Service Commission to urge Congress to enact the preemption clause at issue in this case "giv[ing] the Commission clear authority to issue regulations restricting the application of State laws when their provisions do not parallel the provisions in the Commission's health benefits contracts." S. Rep. No. 95-903, at 4 (1978) (Appellant's App. 32). In response, Congress enacted § 8902(m)(1) to "clarify the Federal Government's and the Civil Service Commission's authority to regulate implementation of the law." *Id.* It has thus been clear since the enactment of the preemption clause in 1978 that the agency has authority to issue regulations regarding the scope of FEHBA preemption.

2. In arguing the contrary, plaintiff declares that "an agency's formal statements ... are only entitled to deference if Congress has *explicitly* 'authorize[d]'

the agency 'to pre-empt state law directly.'" Pl. Br. 40 (quoting *Wyeth* v. *Levine*, 555 U.S. 555, 576 (2009)). But the Supreme Court has repeatedly rejected plaintiff's premise, Pl. Br. 41-42, that Congress is required to use particular magic words in order to make a delegation regarding preemption effective. *See, e.g.*, *City of Arlingon*, 133 S. Ct. at 1871; *Smiley*, 517 U.S. at 743-44. *Wyeth*, on which plaintiff heavily relies for that notion, certainly stands for no such proposition. *Wyeth* involved no notice-and-comment regulation, but rather a preamble that conflicted with the agency's traditional position on the matter. *Id.* at 576-77. The Court was careful to caution that it was not considering "the pre-emptive effect of a specific agency regulation bearing the force of law." *Id.* at 580.

Here, OPM has promulgated a formal regulation thorough notice and comment—which is within the heartland of agency action entitled to *Chevron* deference. *See City of Arlington*, 133 S. Ct. at 1868-73; *United States* v. *Mead*, 533 U.S. 218, 230 (2001). Congress, moreover, made FEHBA preemption turn on what FEHB contract terms require of FEHB beneficiaries, which OPM has express authority not only to negotiate and interpret, but also to promulgate rules regarding. *See* 5 U.S.C. § 8902(a); 8913(a); 5 C.F.R. § 890.105(a)(1); *see also Wyeth*, 555 U.S. at 576 (citing 21 U.S.C. § 360k as an example of an explicit delegation of preemption authority) *Medtronic*, 518 U.S. at 484 n.5, 496-97 & n.15 (upholding delegation of preemption authority to the FDA under § 360k because Congress made preemption turn on what on "requirements" promulgated by the agency conflicted with state law). The effect of state law on the welfare of FEHBA beneficiaries under the terms of FEHB contracts that OPM itself negotiated falls

squarely within OPM's specialized expertise, and it is clear that Congress delegated authority to the agency to speak to it through rulemaking.

Contrary to plaintiff's suggestions, Pl. Br. 44-54, OPM's rule reflects careful analysis of not only the underlying FEHB contracts, but also the text, purpose, and history of the FEHBA preemption provision. *See Helfrich*, slip op. at 34-35. As OPM, the Supreme Court, and this Court have all recognized, it is plausible to understand a condition or limitation on the receipt of benefit payments to be "related to" benefits and benefit payments on the face of the statute. 80 Fed. Reg. 931, 932 (Jan. 7, 2015); *McVeigh*, 547 U.S. at 697; *Nevils*, 418 S.W.3d at 545-55. And not even plaintiff questions OPM's further conclusion that state anti-subrogation laws, in turn, "relate to health insurance or plans" within the meaning of the statute and therefore are preempted. *See* 5 C.F.R. § 890.106(h).

FEHB contracts, moreover, concern the health benefits the federal government provides to its own employees. As OPM found, this interpretation of the preemption clause and the FEHB contract terms "furthers Congress's goals of reducing health care costs and enabling uniform, nationwide application of FEHB contracts." 80 Fed. Reg. at 932 (citing FEHBA legislative history). OPM determined, in particular, that state anti-subrogation and reimbursement laws are unfair to FEHB beneficiaries because they make beneficiaries' entitlement to benefit payments, even under nationwide FEHB plans with uniform rates, depend on the accident of their state of residence. *See* 80 Fed. Reg. at 932. As the Tenth Circuit concluded, this "longstanding and persuasive-

ly explained view" is plainly entitled to deference. *Helfrich*, slip op. at 38-39.

3. Plaintiff argues that the OPM regulation contravenes the "presumption against preemption." Pl. Br. 44. The Tenth Circuit in *Helfrich*, however, correctly concluded that no such presumption applies to FEHBA. The court reasoned that "[t]he federalism concern (respecting state sovereignty) behind the presumption against preemption has little purchase in this case," given that FEHBA "governs only contracts for the benefit of federal employees." Slip op. at 30. Where contract terms relate to benefits, FEHBA expressly displaces conflicting state laws that, in turn, "relate[] to health insurance or plans." 5 U.S.C. § 8902(m)(1). "It is an understatement to say that there has been a history of significant federal presence in the area of federal employment." *Helfrich*, slip op. at 30 (internal quotation marks and citation omitted). The Court should not presume that Congress intended a patchwork of state laws to govern the provision of health insurance benefits to federal employees.

In any event, the Supreme Court has held that any presumption against preemption, even if otherwise applicable, cannot overcome an agency regulation adopting one of two plausible interpretations of an express preemption clause. The Court was faced with that question in *Smiley*. In analyzing whether the agency reasonably interpreted the statute to preempt state law, the Supreme Court refused to apply a presumption against preemption, and rejected the argument that such a presumption "trumps *Chevron*" where, as here, an agency is interpreting a statute that unquestionably is preemptive. *See Smiley*, 517 U.S. at 743. The agency's rule, in short, au-

thoritatively resolved any preexisting ambiguity in the statute. *See Brand X*, 545 U.S. at 980-86.

Plaintiff misreads the *Smiley* decision to leave open the question whether the presumption against preemption applies to an agency regulation construing an express preemption clause. Pl. Br. 47-48. But *Smiley* was clear that the presumption against preemption does not "trump[] *Chevron*" where, as is the case here, an agency promulgates a regulation construing the meaning of "a statute" that "is preemptive." 517 U.S. at 743-44. The question *Smiley* left open is whether that same rule applies to a regulation construing a statute that *does not* expressly preempt state law—an issue the Court noted was "*not* the question" before it because there was no doubt that the provision before it "pre-empt[ed] state law." *Id.* at 744; *see also id.* at 737 (discussing the preemption clause in Section 30 of the National Bank Act). The question left open in *Smiley* therefore has nothing to do with this case, which, as in *Smiley*, concerns the substantive meaning of a clause that is expressly preemptive.

4. Plaintiff also contends that OPM overlooked the constitutional-avoidance doctrine in interpreting FEHBA to preempt state anti-subrogation law. Pl. Br. 45-47.[21] But the OPM regulation does avoid any constitutional issue. It interprets § 8902(m)(1), a federal statute, to preempt state law in certain circumstances. *See* 5 C.F.R. § 890.106(h); *Empire*

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[21] Plaintiff's preferred interpretation, in any event, does not avoid the purported constitutional problem, because plaintiff apparently agrees that the statute preempts "state laws that would compel FEHB carriers to cover certain types of health benefits or comply with certain coverage-related issues." Pl. Br. 50.

Healthchoice Assurance, Inc. v. *McVeigh*, 396 F.3d 136, 144 (2d Cir. 2005) (Sotomayor, J.), *aff'd*, 547 U.S. 677 (2006). That is an eminently reasonable reading of the statute, which does not make contract terms themselves preemptive of state law, even where those terms may relate to benefits or benefit payments. Instead, preemption is triggered only if the relevant state law, in turn, "relates to health insurance or plans." 5 U.S.C. § 8902(m)(1). It is therefore the statute itself that picks out which state laws are preempted. OPM's reading is a plausible interpretation of the preemption clause, and avoids the constitutional concerns expressed by Judge Wilson the last time this case was before this Court. *See Nevils*, 418 S.W.3d at 464-65 (Appellant's App. 11). Federal statutes routinely provide for preemption of state law based in part on the terms of contracts. *See, e.g.*, *Hillman* v. *Maretta*, 133 S. Ct. 1943, 1948-49 (2013) (involving 5 U.S.C. § 8709(d)(1)); 5 U.S.C. §§ 8959, 8989, 9005(a); 9 U.S.C. § 2; 10 U.S.C. § 1103(a); 29 U.S.C. § 1144(a). Statutes of this kind present no Supremacy Clause problem.

CONCLUSION

The judgment of the Circuit Court should be affirmed.

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NOVEMBER 2015

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